JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

HOSPITALS

FEBRUARY 1, 1959

ARE EDUCATIONAL
STANDARDS TOO HIGH
IN THE PARAMEDICAL FIELDS?
(PAGE 31)

WHAT THE PLANNER
HAS TO WORK WITH
(PAGE 33)

A CHRONIC DISEASE UNIT IN A GENERAL HOSPITAL (PAGE 26)

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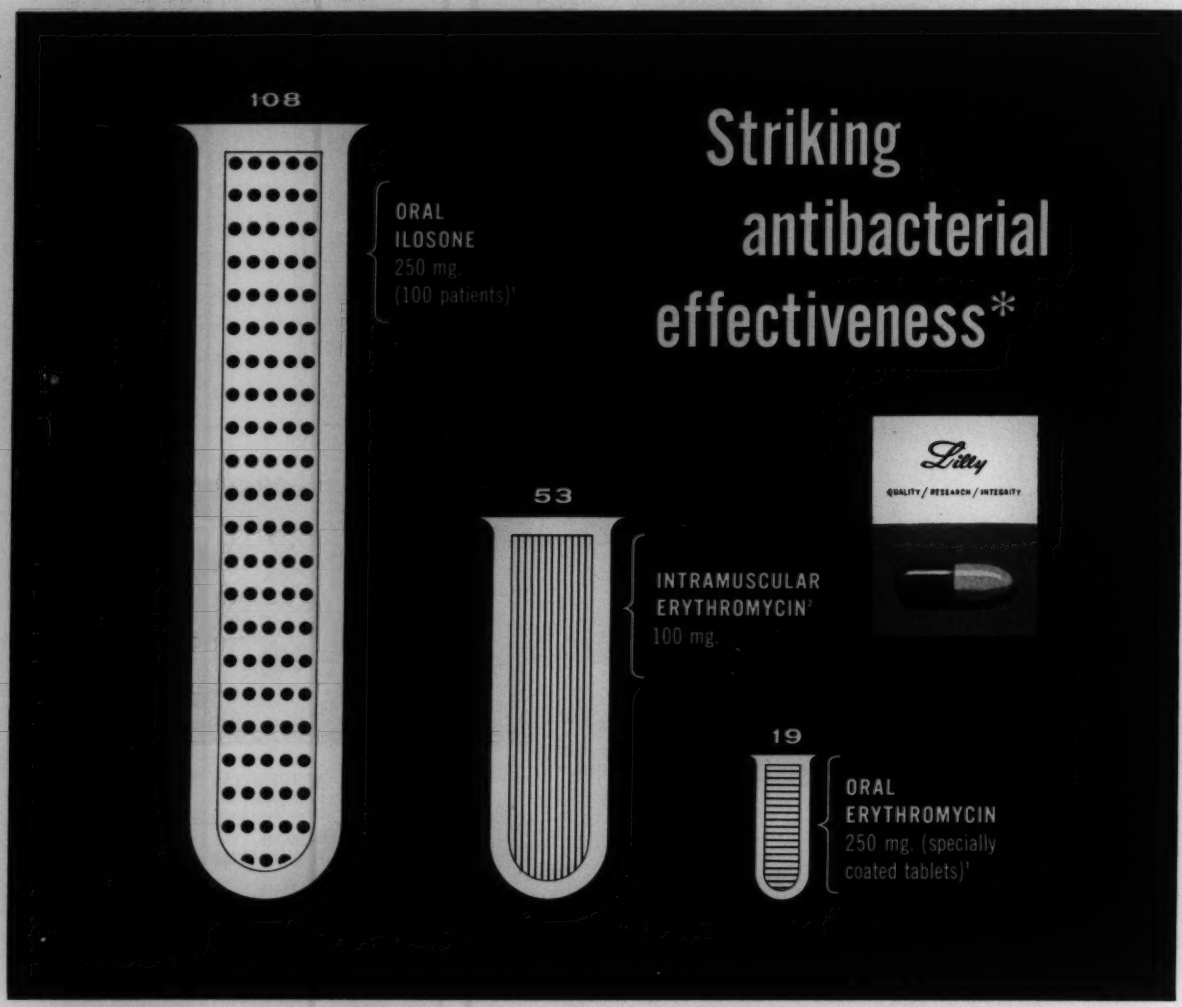

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1. Griffith, R. S., *et al.*: Antibiotic Med. & Clin. Therapy, *5*:609 (October), 1958. Note: Peak levels with the oral erythromycin tablets (thirty-three dilutions) were not observed until four hours after administration. 2. Data from Griffith, R. S.: Antibiotics Annual, p. 269, 1954-1955.

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Occupational therapy in pleasant surroundings is one of many rehabilitative measures available at the chronic disease division of Jewish Hospital of St. Louis. Part I of a comprehensive two-part article describing this facility begins on page 26. Photo by Harold Ferman. (Other picture credits on page 96.)

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Feb. 4-5—**Midyear Conference of Hospital Association Presidents and Secretaries,** Chicago

Aug. 24-27—**61st annual meeting,** New York City (Coliseum; Statler Hotel)

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium)

MEETING AND INSTITUTE CALENDAR

THROUGH JUNE 1959

(American Hospital Association institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. *Other organizations in the health field are shown in ITALICS.)*

FEBRUARY

5-7 ***American College of Hospital Administrators,*** Congress on Administration, Chicago (Sherman Hotel)

8-10 ***American Medical Association,*** Congress on Medical Education and Licensure, Chicago (Palmer House)

9-13 **Hospital Purchasing,** New York City (Statler Hotel)

16-19 **Nursing Inservice Programs,** Kansas City, Mo. (Bellerive Hotel)

23-27 **Dietary Department Administration,** New Orleans (YWCA)

23-27 **Nursing Service Administration,** Fresno, Calif. (Fresno Hacienda Motel)

MARCH

2-4 **Hospital Safety and Insurance,** Toronto, Ont. (King Edward Hotel)

4-6 Quebec Hospital Association, Montreal (Windsor Hotel)

5-6 Georgia Hospital Association, Augusta (Bon Air Hotel)

5-7 Louisiana Hospital Association, Baton Rouge (Bellemont Motor Hotel)

9-11 **Advanced Institute for Directors of Hospital Volunteers,** Chicago (AHA headquarters)

12 Wisconsin Hospital Association, Milwaukee (Hotel Schroeder)

16-19 **Obstetrical Nursing Administration,** St. Louis (Coronado Hotel)

16-20 ***National Health Forum,*** Chicago

17-19 ***National Health Council,*** Chicago (Palmer House)

23-25 New England Hospital Assembly, Boston (Statler Hotel)

30-Apr. 3 **Dietary-Housekeeping-Nursing Department Relationship,** Chicago (AHA headquarters)

31-April 2 Kentucky Hospital Association, Lexington (Phoenix Hotel)

APRIL

1-3 Mid-West Hospital Association, Kansas City, Mo. (Municipal Auditorium; President Hotel)

6-9 Ohio Hospital Association, Columbus (Veterans Memorial Auditorium; Deshler-Hilton Hotel)

6-9 ***American Academy of General Practice,*** San Francisco

8-10 Southeastern Hospital Conference, Atlanta (Atlanta-Biltmore Hotel)

9-10 New Mexico Hospital Association, Albuquerque (Western Skies Hotel)

12-16 ***Annual Conference of Blue Cross Plans,*** Chicago

13-17 **Hospital Engineering,** Baltimore (Lord Baltimore Hotel)

16-17 Carolinas-Virginias Hospital Conference, Roanoke, Va. (Hotel Roanoke)

20-23 **Evening and Night Nursing Service Administration,** Buffalo, N.Y. (Lafayette Hotel)

22-24 South Dakota Hospital Association, Huron

23-24 Iowa Hospital Association, Des Moines (Savery Hotel)

27-29 Tri-State Hospital Assembly, Chicago (Palmer House)

27-May 1 ***American Psychiatric Association,*** Philadelphia

27-May 1 ***National Association for Practical Nurse Education,*** Cincinnati (Netherland-Hilton Hotel)

28-May 1 **Occupational Therapists,** Waco, Tex. (Roosevelt Hotel)

MAY

4-7 Association of Western Hospitals, Salt Lake City, Utah (Utah Hotel)

(Continued on page 90)

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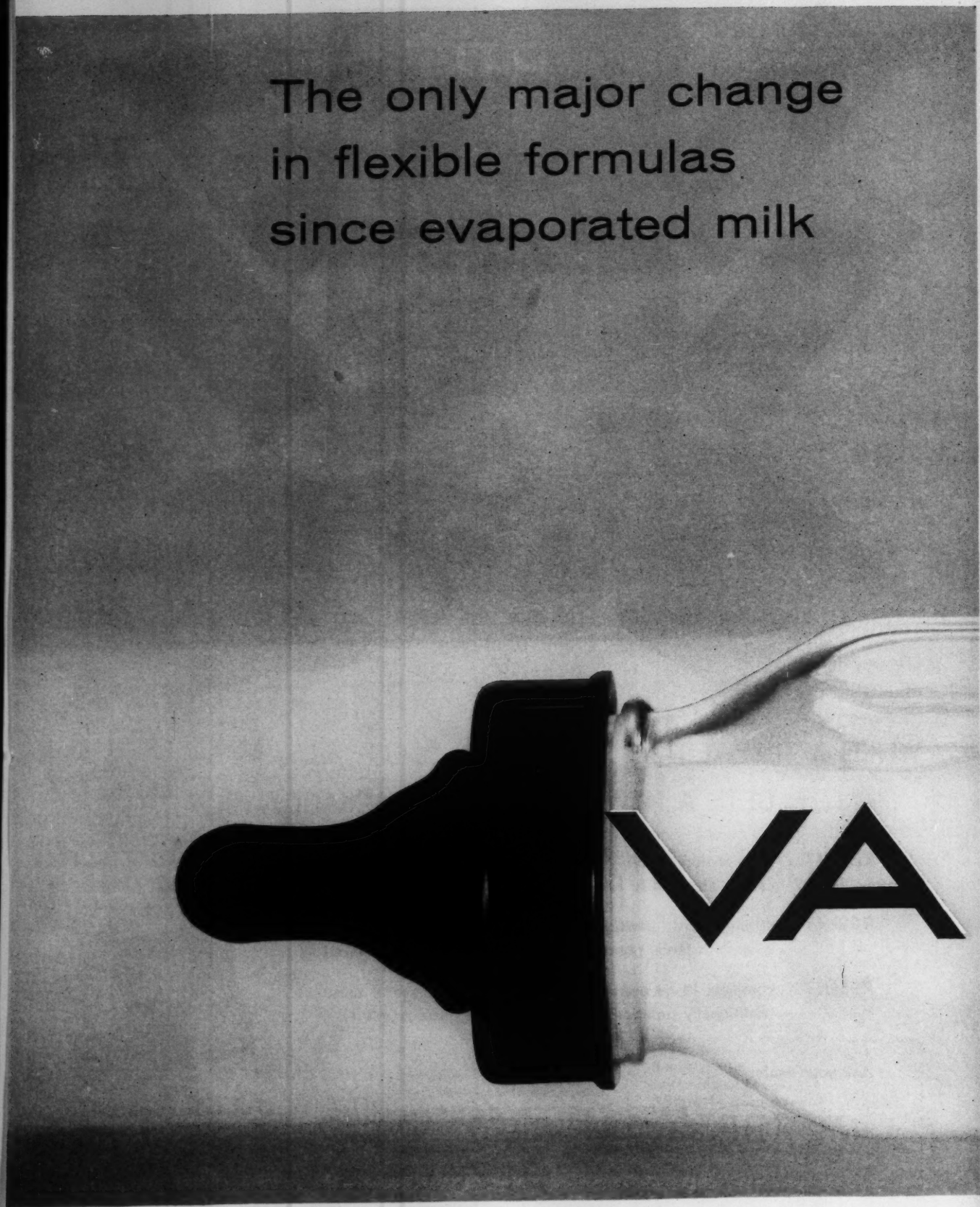
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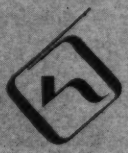

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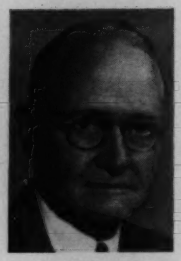
1. Hansen, A.E., et al. J. Nutrition 66 345 (1958) 2. Hansen, A.E. et al. Ibid p. 565

introducing the authors

Charles F. Neergaard has been a consultant to hospitals for 35 years. He brings an unusually varied background to his profession. In addition to his work as a consultant, Mr. Neergaard has served for many years as a hospital trustee, and as a lecturer, author, and designer.



MR. NEERGAARD

During his career, Mr. Neergaard has advocated the adoption of insulation and double glazing in hospitals and other large buildings for economy and simplicity. He returns to these two points and sums up his experience regarding wasteful heating and ventilating in the two-part article beginning on p. 65.

Mr. Neergaard graduated from Yale University in 1897. During World War I, he served as a field director of the American Red Cross. He was inspector of the 22 hospitals of the Atlantic Division of Red Cross and also directed Red Cross work in the U.S. Debarkation Hospital at Grand Central Palace, N.Y.

The first hospital he helped design, Carson C. Peck Hospital, Brooklyn, N.Y., opened in 1919. Since then he has collaborated with architects and engineers in the design and construction of more than 200 buildings. Mr. Neergaard and the firm with which he is associated, Neergaard, Agnew, Craig & Westermann, have also advised more than 350 hospitals in the past 30 years.

Mr. Neergaard is a life member of the American Hospital Association. He served for three years as chairman of the AHA's Committee on Hospital Planning and Equipment and also as a member of the AHA's air conditioning committee.

To encourage development of improved standards of hospital design, Mr. Neergaard sponsors a fellowship in hospital architecture at Yale University. Since his retirement in 1952, he has spent much of his time promoting the principles of insulation.

Nathan Bushnell, III, suggests that a relaxing of educational requirements can help reduce the personnel shortages confronting many paramedical groups. This approach, writes Mr. Bushnell in his article which starts on p. 31, offers prompt relief from these shortages.

MR. BUSHNELL

Administrator of Franklin Memorial Hospital, Rocky Mount, Va., Mr. Bushnell is also chairman of the Health Personnel Committee of the Virginia Council on Health and Medical Care. He graduated from the Medical College of Virginia School of Hospital Administration in 1951.

Mr. Bushnell has been a consultant on several hospital projects, vice president of the Roanoke Area Hospital Council and a member of the executive committee of the Virginia Hospital Association.

In 1955 and 1956, Mr. Bushnell developed and published a program for introducing high school students to the hospital. The paper was later translated by the United States Information Agency and distributed abroad.

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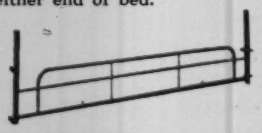

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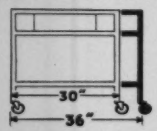

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With head or foot piece removed, end of bed is flush with mattress surface, allowing a direct pull at mattress level for traction with Bucks Extension.

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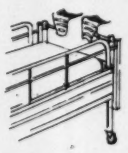

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digest of NEWS

REPORT FROM WASHINGTON—President Eisenhower did not specify what health programs the administration is considering for increased expenditures, although he said in his State of the Union address that "next year we will be spending an increased amount on health programs." Details p. 81.

- Some 200 of the more than 2000 bills introduced in Congress on its opening day deal with the federal government's role in hospital-medical affairs. The most important of these are briefly outlined on p. 82.
- Rep. Aime J. Forand (D-R.I.) has expressed his belief that his proposal for using the social security mechanism as a means for providing hospital-medical benefits for the aged has a good chance of being passed by Congress this year. Details p. 82.
- A bill introduced by Rep. James Morrison (D-La.) to underwrite part of the cost of hospital-medical insurance for federal employees is destined for early hearings. Details p. 82.
- A House committee chaired by Rep. Wilbur Mills (D-Ark.) is planning to revise and simplify the federal tax system. The committee is also to review the exemption status of many nonprofit organizations, including hospitals. Details p. 81.

CHANGES SEEN IN ROLE OF HOSPITAL PHARMACIST—Among the changes predicted for tomorrow's pharmacist are that:

- He will be better educated than he is today.
- He will have more versatility in hospital management.
- He will be less of a technician and more of an executive.
- There will be, proportionately, less "he's" and more "she's," with women holding down a predicted 25 per cent of future hospital pharmacy jobs.

Four panelists at the 1958 annual meeting of the American Association for the Advancement of Science, Dec. 26-31, Washington, D.C., made these predictions. Details p. 52.

18 BECOME LIFE MEMBERS OF AMERICAN HOSPITAL ASSOCIATION—Details p. 89.

AREA COUNCIL, STATE ASSOCIATION MAP PLANS FOR USE IN DISASTERS—Erie County, N.Y., (Buffalo) hospitals have agreed to follow a specific set of procedures should a disaster strike the area, the Western New York Hospital Council has reported. Details p. 87.

- The California Hospital Association has issued an outline of a disaster plan which hospitals may adapt for their own use. Details p. 87.

SURVEY SHOWS MOST NEW YORK HOSPITALS DO NOT ACCEPT ALCOHOLIC PATIENTS—Only 35 per cent of public general hospitals in New York State, 20 per cent of the voluntary general hospitals, and 9 per cent of the proprietary general hospitals will accept patients with a primary diagnosis of alcoholism. This information and some of the reasons why hospitals hesitate to admit alcoholics are detailed in a report made by the New York State Interdepartmental Health Resources Board and the Hospital Association of New York State. Details p. 88.

ADMINISTRATORS DISCUSS EXPERIENCE GAINED FROM CHICAGO SCHOOL FIRE—The Chicago Hospital Council recently sponsored a symposium at which the administrators of the four hospitals which provided care for the victims of the Dec. 1, 1958, Our Lady of the Angels School fire, Chicago, told how their hospitals responded to the emergency and discussed how a future disaster might be handled more efficiently. Details p. 88.

U.S. MAKES GRANTS FOR HOSPITAL ADMINISTRATION RESEARCH—Some $76,047 in grants for five Public Health Service sponsored research projects in hospital administration and services have been approved by the Federal Hospital Council.

Grants of this type are made under the Hospital and Medical Facilities Survey and Construction (Hill-Burton) Program. A total of $4.8 million has been appropriated for this type of research since 1956.

The new grants are for: **Highland View Hospital, Cleveland**—$31,165 for the first year of a four-year study of individual patient needs and the care provided in the hospital for chronic disease patients. Condition of the patient will be evaluated at admission, during hospitalization, and following discharge from the hospital. Results of the study are to be applied to improving admission policies, management and care of patients in the hospital, and hospital policies and provision for discharged patients and their posthospital course of treatment and care.

Cornell University, Ithaca, N.Y.—$19,895 for the first year of a three-year study of hospital-community relations. Purpose of this study is to evaluate the attitudes of several communities to their hospitals, based on a series of specific criteria of activity and performance, both inside the hospital and in the community.

United Hospital Fund of New York, New York City—$13,750 to complete an existing project on research and

Worth Quoting

". . . The cult of bigness has erected many shrines in modern America. That bigness is here to stay is inevitable. That it must be achieved at the expense of greatness is not inevitable . . ."—William Frederick Norwood, *chairman, Division of Legal and Cultural Medicine, School of Medicine, College of Medical Evangelists, Loma Linda and Los Angeles, Calif., before the 69th annual convention of the Association of American Medical Colleges, October, 1958, Philadelphia.*

education in management and operations improvement.

University of Minnesota, Minneapolis—$8943 for a one-year study to explore the possibility of developing an organized program of education for training research people in hospital administration.

University of California, School of Public Health, Berkeley—$2294 for a one-year pilot study to determine whether, and to what degree, the small hospital provides material for research in hospital administration.

SPRINGER NAMED OFFICER OF PENNSYLVANIA BLUE CROSS PLAN—Edward L. Springer, deputy attorney general of Pennsylvania for the past four years, has been elected a vice president of the Hospital Service Association of Western Pennsylvania (Blue Cross), Pittsburgh.

Mr. Springer will serve as staff legal counsel and as administrative officer for the Blue Cross Plan.

Mr. Springer was deputy attorney general assigned to the Pennsylvania Insurance Department during the 1958 rate hearings and the adjudication which followed them (see **HOSPITALS**, J.A.H.A., May 16, 1958).

Mr. Springer has also served (1949-51) as legal counsel to the U.S. Senate Majority Policy Committee and as legal counsel to the Senate majority leader.

DR. ERNEST E. IRONS, FORMER AMA PRESIDENT, DIES—Dr. Ernest Edward Irons died in Chicago on Jan. 18 at the age of 81. He was president of the American Medical Association in 1949-50. Details in Feb. 16 issue of this Journal.

CLOSING OF HOSPITAL SCHOOLS OF NURSING IN NEW JERSEY RECOMMENDED—A Governor's Interim Commission on Nursing should be established in New Jersey to study the possibility of closing the 35 hospital schools of nursing in the state and placing all nurse education programs in colleges, a college dean recommended.

Dean Ella V. Stonsby, Rutgers University College of Nursing, made this recommendation before a meeting of the New Jersey League for Nursing. She said the commission should be composed of nurses representing education and service, should be headed by a nurse educator, and should be advised by a committee of hospital administrators, legislators, and prominent lay citizens.

Dean Stonsby said that if such a commission were established it should consider: number of schools needed in the state; closing schedule for the 35 hospital schools; relocating hospital school faculties; establishment of state-wide scholarship and recruitment programs; ways of augmenting teaching staffs; possible development of hospital and public health facilities as clinical teaching centers.

Nearly 3000 persons were enrolled in New Jersey's 35 hospital nursing schools last year and 233 were enrolled in the nursing programs of the three university's in the state which offer such courses of study. No state in the country currently requires its nurse education to be given solely through collegiate programs, Rutgers reported.

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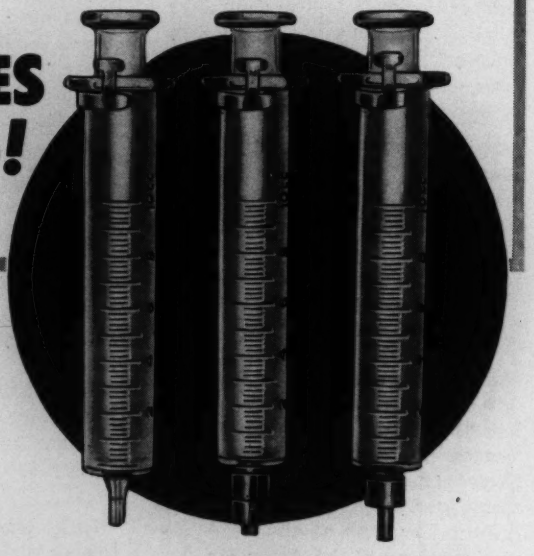

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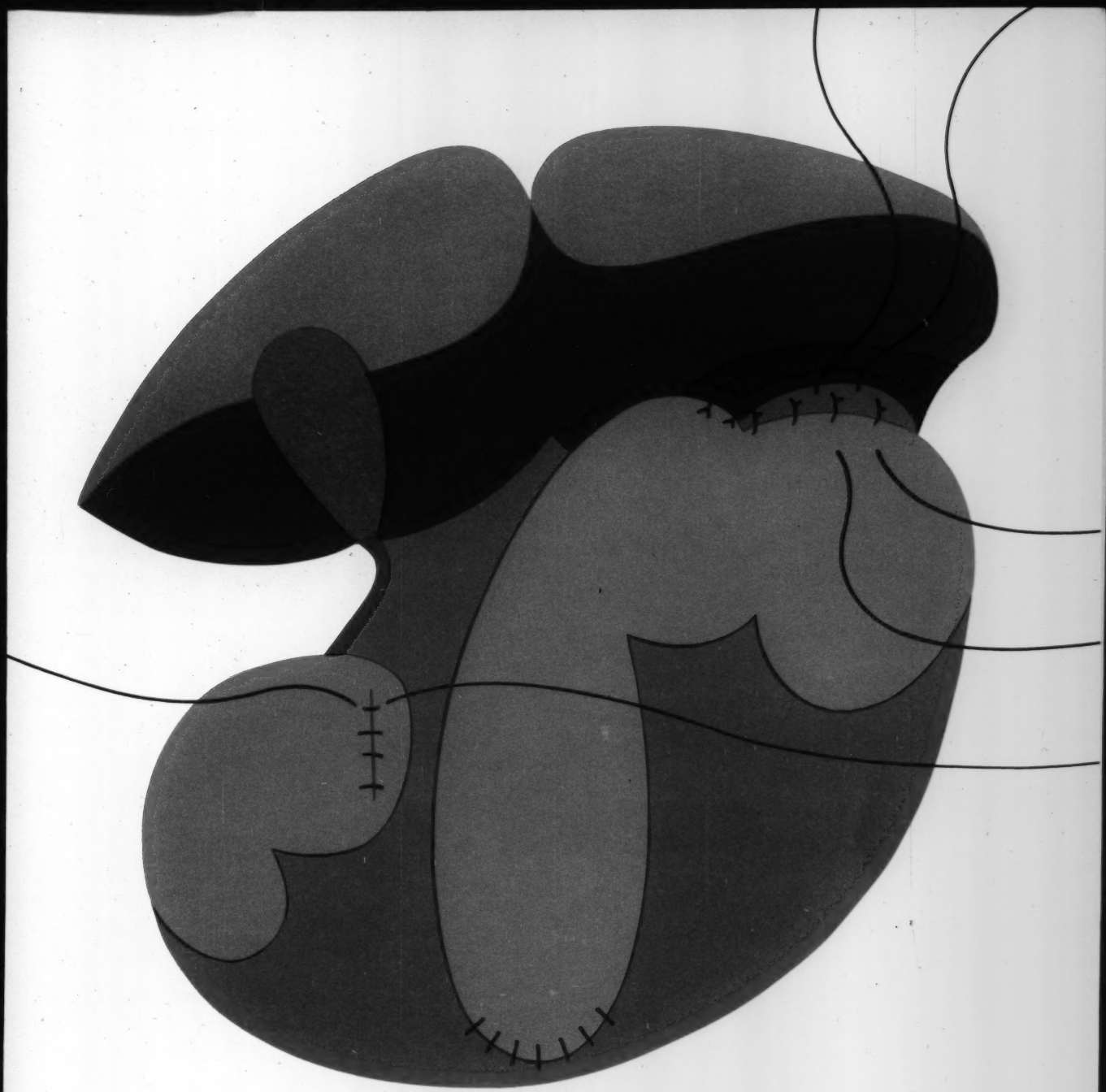

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Legislative program goal

What goals should a state hospital establish for its legislative program on reimbursement for indigent care?

The objective of a hospital legislative program for the indigent and medically indigent should be reimbursement at each hospital's current full cost. There are several facets to such a program and each facet has specific problems that cannot always be resolved. The four major facets in which there should be joint hospital action, include:

1. Uniform hospital accounting and reporting program.
2. Standard hospital cost and certification program.
3. Definitive statement on recipient eligibility for each category of government assistance.
4. Realistic appropriations by state, county and city governments.

The nature of state, county and city appropriations are such that it is unrealistic for hospitals to expect reimbursement at current cost. Appropriations are made in advance of the period in which payments will be made and hospital costs cannot be computed until the period is over. The longer average length of stay of indigent and medically indigent patients, however, gives the hospital a longer period over which to average costs of special services provided. It would seem, therefore, in view of the longer stay, that hospitals need not become seriously concerned over receiving current costs as long as they receive full costs for the most up-to-date period for which hospital costs can be made available.

The definition of full costs poses several problems. While the standards set up by the American Hospital Association in its *Principles of Payment for Hospital Care* have received wide acceptance, depreciation is not allowed in some states and interest is not allowed in some others. Acceptance of the standards can best be achieved through a continuing program of education aimed at key government officials.

The form of cost reporting is of prime importance to hospitals. The accounting handbook and the manual *Cost Finding for Hospitals* published by the AHA, provide a solid basis for such reporting.

The audit of hospital cost reports is an important and necessary part of a cost reimbursement program. Since hospitals are apt to make errors in computation, there would seem to be advantages in having the cost reports either audited or reviewed before they are submitted to a government agency. As part of such review, a procedure should be established for hearings at which hospitals can present their position on items which they have included in their cost report but are not accepted. A similar procedure should also be established under a government audit program.

If hospitals set up their own audit or review program of hospital costs, a certification procedure is needed. The form it will take depends on what part the hospital and the certified public accountant play in computing individual hospital costs and in their review. Hospitals should recognize that reimbursing agencies need to justify the propriety of payments. A certification program will protect both hospitals and government assistance agencies.

Standards of eligibility for government assistance programs vary from state to state with respect to the medically indigent. In Pennsylvania, New Jersey and Maine, the hospital has responsibility for determining who is medically indigent. In New York, Connecticut and Massachusetts, acceptance of a medically indigent person for government assistance is the responsibility of a welfare agency.

There are advantages to both plans. In Pennsylvania, hospitals get about half the cost of care but are able to include their entire load of medically indigent. In Connecticut, hospitals receive at least 95 per cent of their individual costs but are dependent on the welfare department to accept the indigent for assistance. In Pennsylvania, additional funds need to be found to pay the balance of the cost of hospital care. In Connecticut, funds need to be found for those medically indigent who are not accepted for assistance by the welfare department. Hospitals have a choice of which system to promote.

Realistic appropriations are the key to realistic hospital reimbursement. This involves practical politics, as well as the three facets already discussed. As early as six months prior to the date on which a legislative body, whether state, county or city, is to meet, hospitals should be prepared to discuss the budget with the responsible government official. From that point on hospitals should be prepared to appear in support of the budget figure before the governor, county judge, mayor, or any one of the legislative bodies involved.

In a number of states, the failure to secure realistic appropriations for government assistance programs has required the establishment of reimbursement ceilings. Ceilings have the effect of retarding the expansion and improvement of hospital services, of putting a financial pressure on private patients and on reimbursement programs, and of penalizing the hospital which provides a broad spectrum of patient services.

It is to the interest of such hospitals and of prepayment plans to take the leadership in the establishment of a program of uniform accounting and reporting, and a program of political action.

—HIRAM SIBLEY

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

(Advertisement)

The 10 questions most often asked about the Control of Staph

Q. ***Where does Staph start from?***

A. First, from an infected patient, then it is everywhere at once. Infection and re-infection are a continuous cycle kept in motion by 1) direct contact from the infected patient to personnel to another patient; 2) direct contact with contaminated objects; 3) contaminated dust and lint settling on or being breathed in by patients and personnel.

Q. ***What is the first thing to do to control the spread of Staph?***

A. Make a thorough study of the problem in your own hospital. Don't overlook any area of hospital service, any patient, or any personnel. This critical evaluation may reveal previously unsuspected sources for infection, particularly in the environment.

Q. ***Do all hospitals have the same environmental problems?***

A. Basically, yes, or the same potential ones. In addition to known infection-sensitive areas – such as nurseries and obstetric wards, operating rooms, pediatric wards, isolation wards–there is the hazard of infectious organisms "travelling" through the entire hospital by whatever means is available to them. As a result–hospital-acquired infections can complicate the patient's case, increase necessary care, and jeopardize complete recovery. Hospital personnel may become carriers or even patients.

Q. ***How does Staph "travel"?***

A. Staph is a pathogenic parasite which, once outside the human host, attaches itself to dust and lint and lurks there waiting to be stirred up into the air where it can invade the human host through the respiratory tract or open wounds. In human tissues, Staph is hard to kill as it multiplies aggressively and resists most antibiotics. In the environment, dormant Staph can live for months – but *it can be reached and killed quickly if the proper measures are taken.*

Q. ***What are the "proper measures" to kill environmental Staph?***

A. Disinfection. Routine use of the proper type of disinfectant on any or all surfaces which can become contaminated by airborne dust and lint, by spray from mouth and nose, or by direct contact–floors, walls, furniture, equipment, etc. Use of the same type disinfectant for blankets and linens from which contaminated lint can come.

Q. ***What is the "proper type of disinfectant"?***

A. Phenolic disinfectants have been proved effective by every standard laboratory test and in actual hospital infection. In a special report[1] on the A.M.A. Conference on Staphylococcic Infections, John W. Brown, M.D., states, "The frequent and thorough application of the phenolic germicides (disinfectants) in proper concentration has accomplished more toward eliminating airborne bacteria from a hospital environment than any other method".
Lehn & Fink's Amphyl®, O-syl®, Lysol®, and Tergisyl™ are all phenolic compounds.

Q. ***Do these Lehn & Fink disinfectants kill other organisms besides Staph?***

A. Yes. The action of L&F disinfectants is termed "broad spectrum". Besides being staphylocidal, they are tuberculocidal, fungicidal and widely bactericidal–killing organisms common to the hospital such as those causing infant diarrhea.

Q. ***What about costs? Will increased control measures increase operating costs of the hospital?***

A. No. After continued experience with Lehn & Fink disinfectants, Ralph Adams, M.D., reports,[2] "An important job recognized as such, interested personnel, and good methods are all needed to achieve a cleaner, safer hospital – yet at no substantially greater maintenance cost–particularly when the cost of infections is taken into account". A well-correlated infection control program can stabilize operating costs.

Q. ***Whose responsibility is it to see that there is a "well-correlated" infection control program?***

A. First, the administrative head of the hospital, but he cannot do it alone. He needs an effective Infection Committee to assist him. Real control requires the help of every department head and everyone in each department. Much specific information is available on procedures which apply to specific departments. The Administrator needs the cooperation of everyone in establishing standardized methods. Since the Housekeeping Department reaches into every part of the hospital and has the job of keeping the environment aseptically clean, its responsibility is great.

Q. ***Where can the hospital turn for practical information on disinfection methods?***

A. To improve control quickly, the best source is the established disinfectant manufacturer. Lehn & Fink has been solving the problems of environmental disinfection in hospitals since 1874. We hope you will draw on this experience. The information we can provide will save time and trouble in analyzing your infection problem and instituting effective controls. Amphyl, Lysol, O-syl and Tergisyl are all effective phenolic disinfectants. Each has individual characteristics which frequently determine your choice for standardized use. Samples and detailed literature will gladly be sent on request.

Why not let Lehn & Fink help you prevent or control Staph infection? All of our disinfectants have been both laboratory and hospital-use tested against antibiotic resistant strains of Staph. Technical assistance is available to your Infections Committee or individual department heads.

AMPHYL®, LYSOL®, and O-SYL® disinfectants and TERGISYL™ detergent-disinfectant are staphylocidal, bactericidal, fungicidal and tuberculocidal.

1. J.A.M.A. 166:1185, Mar. 8, 1958. 2. Res. Physician 4:112, Sept. 1958.

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opinions and ideas

LETTERS TO THE EDITOR

Flecked with praise

Dear Sir:

We have read with interest the article entitled "Fleck Paint: It Costs More, But . . ." by David M. Smith [HOSPITALS, J.A.H.A., May 1, 1958, p. 59] and we are happy to see that color-flecked paints are beginning to receive the editorial attention we have long felt they deserved.

In this connection, however, we were somewhat distressed to note the emphasis the article laid on the need for ventilation and the "pungent" odor of the paint, particularly since we have advertised our new, odorless-type color-flecked paint on at least three occasions in your publication, October and November 1957 and January 1958.

Odorless-type Plextone is a *non*-lacquer-base and the "odor problem" mentioned in the article has, accordingly, been minimized to a considerable degree. As we have stated in our advertisement, two great paint advantages have been combined into one in this new Plextone. Because it is practically odorless, one room can be painted while an adjacent room is in use. Because it dries faster than ordinary paint you can avoid costly delays in routine.

We sincerely hope that some editorial recognition will be given to the technical advances that we have made in fleck paint and shall anxiously await your comments. —B. F. AMES, *vice president, Plextone Corporation of America, Newark 4, N.J.*

Gift policy for all

Dear Sir:

The letter on gift policy published in the Journal of Nov. 1 (p. 44) has drawn considerable interest at this hospital and most certainly is a timely one.

However, it is the opinion of the staff at this hospital that this problem was limited to the purchasing activities of the hospital. We wish to point out that this is a problem for all hospital personnel and we would call your attention to the fact that purchasing people are probably the most conscientious concerning this matter, but that little is said concerning all other hospital employees who from time to time receive gifts. By all other hospital employees, we would most certainly include administrative personnel.

Thank you for the inclusion in your magazine of such a suggestion, but hope that you would call attention to the fact that its effectiveness will only be experienced if it is appreciated by all hospital employees.—JOHN M. DANIELSON, *administrator, Evanston (Ill.) Hospital.*

Credit for Gatch

Dear Sir:

I read with a great deal of interest in the October 16, 1958, issue of HOSPITALS, J.A.H.A. the article by Gailani *et al.* "A History of the Hospital Bed" I was struck by the idea of giving doctors credit for their help in developing hospitals beds. On p. 42 Doctor Urie is mentioned and on the same page Doctor Hewson.

However, on p. 40 the Gatch spring is mentioned, but no one would know that Gatch is the name of a doctor too. The dictionary gives W. D. Gatch, American surgeon. I had my training as a nurse in Indiana where Doctor Gatch practiced and we were told that he, with the help of an engineer, was the one who put the back rest and the knee rest on the beds. He was for several years the dean of Indiana University Medical School located at Indianapolis.

I wonder if the authors used as reference: Gray, Cecil and Gray, Marjory. *The Bed of Clinophil's Vade Mecum.* London: Nicholson and Watson, 1946. 280 pages (26 Manchester Square London W. 1).

While this book deals with the development of beds in general, there is on p. 294 this statement: "The great strides accomplished in medical science have been helped by the supply of bedsteads of all descriptions for hospital use: operating tables, spinal carriages, etc. suitable for any disease."

Also on p. 32 of the same book the authors quote from Burton's *The Anatomy of Melancholy.* "Epicurus' cure. When a sad and sicke patient was brought to him to be cured, he laid him down on a downe bed, crowned him with a garland of sweet smelling flowers, in a faire perfumed closet delicately set out, and after a potion or two of good drink, which he administered, he brought in a beautiful young wench that could play upon the lute, sing and dance."

I did not find Gray's book listed at the end of the article. I thought it might be of some use.—ESTHER MCCLAIN, R.N., *Providence Hospital School of Nursing, Detroit.*

Use of nursing aids

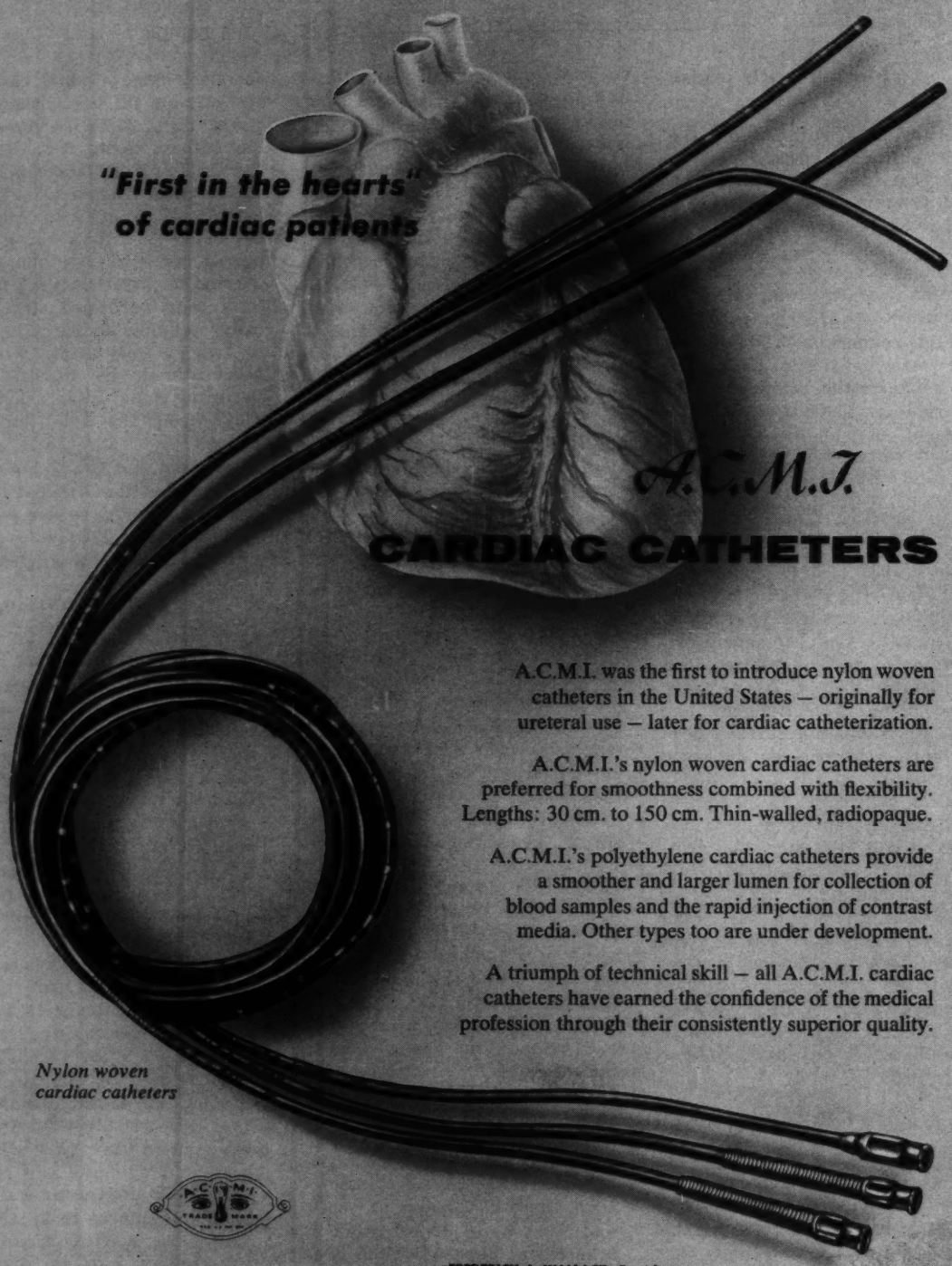
Dear Sir:

In catching up on and reviewing reading recently I reread editorial notes in the Oct. 1, 1958, issue of HOSPITALS, J.A.H.A. In the third column of this editorial it states, "as a matter of fact the Norwalk Conn., hospital has been using nursing aids in an intensive fashion since 1945."

I thought you might be interested in knowing that a few hospital administrators were making great strides in the area of economies in nursing services as far back as the late 1920's and the early 1930's. Albany (N.Y.) Hospital has been using practical nurses since about 1928. This type of nurse was used in the TB units starting in about 1928 and the trial was so successful that they were put on the regular acute hospital nursing units very early in 1930. We started using ward clerks in all nursing units at Albany in 1934. We started training and using nurses aids on all units in 1933.

Dr. Joe Turner, formerly administrator of New York City's Mt. Sinai Hospital, was, I suspect, the first administrator in the country

(Continued on page 90)



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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—reviewing the formulary

APPEARANCE OF A complete collection of drug monographs in more than 3000 hospital mailboxes during the last month marked the beginning of the American Hospital Formulary Service of the American Society of Hospital Pharmacists.* As a part of the service, offered on a subscription basis, subscribers will receive new monographs as new drugs are evaluated.

One of the most important single factors in the service, the ASHP has stated, is that the medical staff of each hospital retains complete authority over drugs to be included in the formulary of the hospital. Thus, working through the Pharmacy and Therapeutics Committee, each medical staff will select from the loose-leaf formulary only those drugs it considers ones of choice. Additional new drugs can be considered by the staff for inclusion in the formulary as monographs are received.

Although the need for some type of formulary service had been recognized and discussed for years, actual work on the American Hospital Formulary Service began in 1954. The service was approved in principle by the Board of Trustees of the American Hospital Association in 1958. It has received similar approval from the Catholic Hospital Association and the American Pharmaceutical Association.

Aside from the obvious advantage of time saved for the Pharmacy and Therapeutics Committee —and the pharmacist as a member of that committee—in preparing drug monographs and compiling a formulary, the medical staff and the committee are given more time for evaluating drugs and attending to other matters related to the distribution and use of pharmaceuticals in hospitals. The service also provides convenient reference for physicians, nurses and pharmacists regarding drugs, their dosage forms, and other pertinent data.

Introduction of the American Hospital Formulary Service focuses attention on the matter of implementing and administering a hospital formulary, whether based on monographs developed in the hospital or by outside sources. Formalities of adopting a formulary, the lines of authority for its administration, the educational aspects of applying it—these and related matters deserve the most careful consideration.

Hospitals adopting the ASHP service can profitably make it an occasion for reviewing their professional policies relating to drugs, making certain that the service is being laid down upon a solid foundation of acceptance and understanding. Hospitals in the latter stages of developing their own formulary can also profit from an appraisal of how well the system will mesh with established policies. The following queries might provide a rough guide for such a review:

- Has the medical staff appointed a Pharmacy and Therapeutics Committee and charged it with the responsibility of formulating broad professional policies regarding the evaluation, selection, procurement, distribution, use, safety procedures and other matters related to drugs in hospitals?
- Are these policies in writing and has the medical staff formally adopted them?
- Do the policies provide for (1) the clinical evaluation of nonformulary drugs by members of the medical staff and (2) the clinical evaluation and control of investigational drugs?
- Has the principle of accepting drugs by their generic names been adopted, even though trade name drugs may be in common use in the hospital?
- Has the medical staff clearly indicated that the formulary system is desirable for the hospital?
- Finally, in the formulation of policies and procedures, has terminology been avoided (such as use of the term "substitution") which impliedly approves the *unauthorized* dispensing of a brand different from that prescribed or the dispensing of an entirely different drug, neither of which takes place under the formulary system?

In addition, many hospitals could profit from a review of their labeling procedures and practices. Attention might be given to problems of correct labeling of pharmaceuticals, with particular reference to the labeling of medications in the pharmacy and on nursing units, being certain that no container carries only a proprietary name when the product is actually made by another manufacturer.

OFFICIAL NOTES

Actions taken by the Board of Trustees of the American Hospital Association at its meetings in Chicago, November 20 and 21, are reported in this issue in the Association Section on page 46.

*How the formulary system affects drug purchasing for hospitals was discussed during a recent meeting of the ASHP and other pharmacy groups. For an account of the meeting, see page 52.

Organizing and operating

A CHRONIC DISEASE

by DAVID LITTAUER, M.D.,
FRANZ U. STEINBERG, M.D., and
DAVID A. GEE

AS PART of the intensive rehabilitation program developed at the chronic disease division, Jewish Hospital of St. Louis, ambulatory patients are encouraged to dress in street clothes.

This report describes the organization and operation of a chronic medical service at Jewish Hospital of Saint Louis, a 500-bed voluntary general hospital. The hospital's long-term services include a 68-bed division for the chronic medical patient, a 31-bed rehabilitation unit for the physically disabled, a 35-bed adult psychiatric unit, and a department of home care now in its fifth year of operation with a steady case load of 50 patients.[1] An inpatient unit for seriously disturbed children has just been activated. The hospital is also responsible for the medical service of an associated old folks home.

In Part one of this comprehensive report, the authors discuss such subjects as types of patients cared for on the chronic disease unit, physical facilities of the unit, staffing arrangements, and admission and discharge procedures. Part two, to be published in the next issue, treats the unit's program of care, the costs, sources and types of income involved in the operation, the relation of the chronic disease facility to other medical care programs, and advantages and disadvantages of the program.

FOR SEVERAL years Jewish Hospital operated a branch chronic disease facility located some 18 miles from the main hospital plant. It was typical of many such institutions. It had a small x-ray and laboratory unit for simple diagnostic work. More complex material was sent to the main hospital for determination. Acutely ill patients were also transferred to the main hospital for treatment and care. The average length of stay was 318 days and the majority of discharges were by death. In 1956 the branch was closed and the patients were moved into new facilities provided at the main hospital.

TYPES OF PATIENTS CARED FOR

It is arbitrary and impractical, in defining the term "long-term patient," to impose such temporal yardsticks as 30 or 90 days of illness. A long-term patient can be defined as a chronically ill person who requires medical care for a long period of time, either at home or in an institution.

Some chronically ill patients can be fully or partially rehabilitated. Intensive medical attention is indicated because it promises improvement of physical and mental states and higher levels of self-care. Other chronically ill patients cannot be expected to improve. Treatment is supportive, to keep them alive and as comfortable as possible.

While diagnostic criteria are helpful in determining whether or not patients can be rehabilitated,

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PART ONE OF A TWO-PART ARTICLE

UNIT IN A GENERAL HOSPITAL

they do not suffice in themselves. For example, some patients with hemiplegia resulting from a cerebral thrombosis quickly reach a level beyond which no further improvement can be expected. Thereafter they will require nursing and protective care but infrequent medical attention. Other hemiplegics with identical clinical cerebral thrombosis will demonstrate that restoration of function is possible. Such patients will benefit from intensive medical attention including rehabilitative methods. Whether the long-term patient should be treated in a hospital, a nursing home or his own home will depend not so much on the original diagnosis as on his current medical needs, and they may change from day to day.

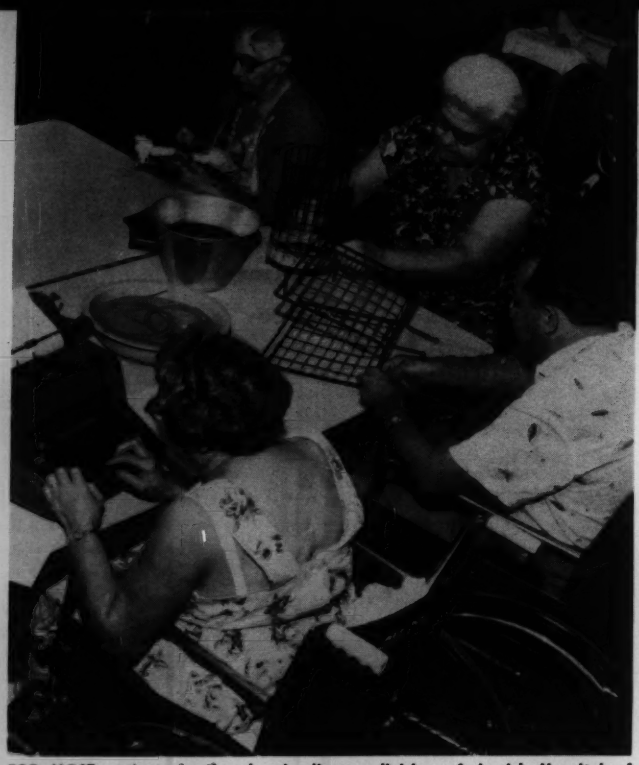
A diagnostic grouping (Table 4, page 30) indicates that most of the diseases which may lead to long-term serious disabilities are represented at Jewish Hospital's chronic disease division.

PHYSICAL FACILITIES OF THE CHRONIC DISEASE UNIT

Chronic disease patients receive care in two nursing divisions totaling 68 beds. Patients with acute, episodic illnesses are not admitted to these divisions.

● **Patient rooms**—One unit, with a complement of 40 beds, is designated for patients who are either bedridden or confined to minimal wheel chair activity. There are 6 single rooms and 17 two-bed rooms. On the floor immediately below is another unit of 28 beds on which are located ambulatory and semiambulatory patients. Four of the rooms are single; one is a four-bed ward and the remainder

PHYSICAL therapy plays an important part in treating long-term patients cared for in the division.



FOR MOST patients in the chronic disease division of Jewish Hospital of St. Louis, occupational and vocational therapy are kept on a simple level. Improved morale rather than prevocational training is of primary concern.

are two-bed facilities.

The design of the rooms is typical of standard patient areas. The two-bed rooms measure 12 by 16 feet. Each is equipped with its own toilet room. The lavatory, however, is located in the room proper to lend flexibility. Two rooms on each division are equipped as isolation rooms. They are sound-insulated for noisy patients and there is a small subutility room between them.

Standard patient room furniture is used with the exception of dressers—drawer space is built in beneath the windows. This arrangement has proved most satisfactory as a space-saving feature. All the rooms are air-conditioned, an important item for geriatric patients in St. Louis summers. Each division is provided with a day room for patients and the usual utility room and galley facilities.

● **Offices**—An office for the medical director of the unit is located on one floor and a small conference room on the other floor. The medical director's secretary has her desk in an alcove off a nursing station and close to his office. In this central location she is available for secretarial duties and at the same time is accessible to relatives of patients, an important function in a long-term unit.

● **Rehabilitation facilities**—Complete facilities for physical and occupational therapy are available to patients of the chronic disease division in the hospital's division of rehabilitation, which serves all programs and services of the general hospital. This division is located on another floor in the same building, easily accessible by elevator. In 1957, chronic disease patients made 3,876 visits to physical therapy, receiving a total of 9,820 modalities. They visited the occupational therapy workshop 1,834 times.

Physical therapy services include gymnasia, for resistive exercises and for ambulation training; a hydrotherapy section with five treatment booths plus a full body immersion tank room; an electrotherapy section with eight treatment rooms; and a shielded electromyography room.

Occupational therapy has two large workshops devoted to many types of diversionary and prevocational activities, and a room equipped for instruction in activities of daily living. Vocational training is provided in the hospital's business office, electronic data processing room, mail and duplicating room, carpenter shop and paint shop.

● **Dining areas**—Since about one-third of the chronic disease division patients are ambulatory and are engaged in various activities during the day, a centralized dining room has been established for their use—as well as for patients from other parts of the hospital. Accommodating 40 patients, the dining room is equipped with conventional dining room tables and chairs, although more than half the patients draw their wheel chairs up to the tables.

Although the patients' dining room was designed with a cafeteria counter and line—in the expectation that a large percentage of patients would handle their own trays as a part of their treatment—it was soon recognized that this was not feasible. Not only are many patients in wheel chairs and incapable of going through a cafeteria line under their own power, but the majority are on special diets which do not lend themselves to cafeteria service from warming tables. Meals, therefore, are brought up from the main kitchen by centralized tray service.

Patients who are semiambulatory, but who cannot conveniently leave the nursing divisions, eat their meals in the day rooms so that they, too, obtain the social advantages of group dining.

● **Recreational facilities**—The centralized dining room is used frequently for recreational activities, such as card games. Other recreational areas available to chronic disease patients include a large auditorium with a stage and movie projection equipment. There is also an attractive roof deck which patients use during good weather.

A patients' library is located on the first floor. In addition to the traditional book cart, patients are encouraged to go to the library to read or to select books. Next to the library is an interdenominational chapel.

STAFFING THE CHRONIC DISEASE DIVISION

The personnel required to operate the two nursing units comprising the chronic disease division may be considered in three

categories: medical, nursing and ancillary.

● **Medical staff**—The division is headed by a medical director who is assisted by two other physicians. Each is a specialist in internal medicine and each devotes about 20 hours to the unit per week. This enables physicians to see each patient at least once a day and more often if necessary. There is a complete range of consultants in all other medical specialties. Consultants in orthopedics, surgery and urology are most often utilized, spending from two to six hours a week with these patients.

House staff coverage by interns and residents is not provided routinely on the chronic disease floors, although house officers are available for emergency coverage at night. Up to this time, it has been the consensus of those responsible for intern and resident training at the hospital that the educational value of assignment in the long-term unit is appreciably less than in an "acute" unit.

A dentist is assigned to the division for routine dental medicine and surgery, as well as a prosthetics program. He spends about two hours a week in this work. A chiropodist provides foot care services an average of two hours per week.

The medical director, his associates, the surgical consultant, the dentist, and the chiropodist receive annual stipends for their work. The cost of these stipends is included in the per diem charge to the patient. All other consultants are on a voluntary basis.

● **Nursing personnel**—It was thought that chronic disease patients would require much less nursing time than acutely ill patients. Experience has shown that this is not the case. The chronic unit averages 3.07 hours of nursing care per patient per day as compared to 3.80 hours on the typical acute medical service. The type of personnel, however, is markedly different. A higher percentage of nonprofessional workers can be utilized. This compares as follows:

NURSING CARE HOURS PER PATIENT PER DAY

	Professional	Nonprofessional	Total
Chronic unit	.79	2.25	3.04
Acute unit	2.45	1.35	3.80

In the chronic unit more emphasis is placed on bedside nursing care and less on technical procedures and treatments. For patients confined to bed, nursing time is heavily devoted to frequent bed changes, turning of patients, feeding of patients, giving medications, and getting them up for brief periods in wheel chairs or walkers. Ambulatory patients must be gotten up and readied for the day's activities. It should be noted that there are fewer admissions on the chronic unit and hence less time is required for many of the scheduling and coordinating activities that nurses on acute divisions must do.

A nursing supervisor is in charge of both divisions. She makes her headquarters on the 40-bed unit, where she is assisted by four other graduate nurses in giving professional coverage around the clock. Other personnel include nine licensed practical nurses and five aides. (Volunteers play an active role on this division in doing simple tasks such as feeding patients at meal times. An average of four volunteers per day are present.)

On the smaller 28-bed unit, there is a head nurse, one other registered staff nurse, seven licensed practical nurses, two aides and three orderlies. The larger number of orderlies on this floor is necessitated by the amount of lifting of patients that must be done throughout the day and evening, as well as the fact that this unit contains the majority of male patients.

● **Ancillary personnel**—Other personnel include a medical social worker and a secretary. The latter is responsible for the correspondence of the physicians, as well as for handling day-to-day matters involving families of long-term patients.

The technical staff of the rehabilitation division plays an important role in the treatment of long-term patients. The equivalent of one physical therapist and one-half occupational therapist are engaged with the chronic disease group. Specific therapists are not assigned to these patients. Rather, each therapist handles a certain number of patients to get a more balanced group with which to work.

An activities of daily living nurse, who is a member of the staff of the rehabilitation division, devotes about a quarter of her time to patients from the chronic disease service.

A recreational therapist rounds out the group. She has a planned program of games, movies, parties, religious activities and other special events. In these activities she uses volunteers a great deal. She works closely with the occupational therapist on handicraft activities, especially for bed patients who cannot get to the occupational therapy workshop.

● **Staffing summary**—The following is the staff we have found necessary for 68 long-term medical patients housed in two nursing units:

- Medical director—1 part-time
- Visiting physician*—2 part-time
- Dentist—1 part-time
- Nursing personnel (40-bed unit)
  - Supervisor—1
  - Staff nurses—4
  - Practical nurses—9
  - Nursing aide—5
- Nursing personnel (28-bed unit)
  - Head nurse—1
  - Staff nurse—1
  - Practical nurse—7
  - Nursing aide—2
  - Orderlies—3
- Activities of daily living nurse—¼
- Social worker—1
- Secretary—1
- Physical therapist—1
- Occupational therapist—½
- Recreational therapist—1

ADMISSION AND DISCHARGE POLICIES

● **Admissions**—It is obvious that a chronic disease service will lose its identity unless admissions are restricted only to patients with medically treatable long-term illnesses. While occasionally a patient who more properly belongs in a nursing home or custodial institution is admitted because of social necessity, nonavailability of facilities elsewhere in the community, or temporary placement, this is the exception. In general, a patient is eligible only if his condition requires care in a hospital setting.

Patients who can receive all the care they need in a nursing home are not accepted, nor are psychotic

*Plus consultants in all medical specialties.

TABLE 1—Functional classification by illness of patients on the chronic disease division during a 12-month period

	NUMBER
Chronic	116
Nursing home	7
Custodial	2
	125

TABLE 2—Sex distribution of patients on the chronic disease division during a 12-month period

	NUMBER
Male	42
Female	83
	125

TABLE 3—Age distribution of patients on the chronic disease division during a 12-month period

AGE AT TIME OF ADMISSION	NUMBER
26-35	1
36-45	3
46-55	14
56-65	19
66-75	35
76-85	43
86-95	10
	125

TABLE 4—Distribution of diagnoses of patients on chronic disease division during a 12-month period

	NUMBER
Congestive heart failure	11
Coronary insufficiency	7
General cerebral arteriosclerosis	13
Hemiplegia	29
Parkinsonism	4
Multiple sclerosis	3
Neoplasms	32
Arthritis	2
Chronic pulmonary disease	3
Chronic renal disease	2
Fractures	4
Amputations	6
All others	9
	125

TABLE 5—Source of patients admitted to chronic disease division during a 12-month period

	NUMBER
Jewish Hospital, acute (private)	54
Jewish Hospital, acute (ward)	39
Jewish Hospital, rehabilitation service	2
Jewish Hospital, home care service	3
Home	19
Nursing homes	3
Other institutions	5
	125

TABLE 6—Classification of patient on chronic disease division during a 12-month period by medicoeconomic status

	NUMBER
Under care of private physician	31
Service case	94
	125

patients who need closed-ward management, nor patients with active tuberculosis or other communicable diseases. Of 125 patients accepted for treatment during a 12-month period, 116 were considered to be medically treatable in a hospital, the other 9 falling into categories of less intensive care. The 125 patients were given 21,101 days of care (Table 1, left).

Two-thirds of the patients admitted were female (Table 2, page 00). While most admissions were between 65 and 85 years of age, the program is not confined to geriatric chronic illness. Of 125 patients, 37 were 65 or under, although only 4 were 45 or under (Table 3, left).

Of the patients admitted to the program, 49 had some sort of neurological diagnosis (chief of which was hemiplegia following a cerebral vascular accident), 32 had cancer and were for the most part in the terminal stages of their illnesses, and 18 had some form of heart disease (Table 4, left).

The chief source of patients was the acute divisions of the hospital, which accounted for 93 of the admissions (Table 5, left). These patients have developed a long-term condition for the first time, or have had an acute exacerbation of a condition of long standing. Thus, the acute services have a ready avenue for discharging patients to a unit that is geared to handle them. The balance of the admissions came from home, the hospital's home care service, or from another institution where they had been receiving some form of care, but where they had either become too ill to be sustained or where there was indication that a different approach to treatment was desirable.

Most patients of the chronic disease division are referred by members of the Jewish Hospital medical staff. Occasional referrals are received from physicians not on the staff of the Jewish Hospital.

● **Private and service patients**—Because of the financial implications of long-term illness, three-fourths of the patients are cared for by the staff physicians as service patients. The balance are private patients cared for by their own physicians (Table 6, left).

Request for admission must come from a physician. Inquiring family members are told to ask their doctors to place applications. The referring physician fills in an admission form, giving a brief summary of the case history. The patient is then seen by the medical director of the chronic disease division who determines medical eligibility. This procedure is followed both for private patients and service cases. The members of the medical staff have accepted this procedure well. They understand that some initial screening is necessary, and by and large they have given excellent cooperation.

If the patient is to be admitted as a service case, the family is interviewed by the credit officer of the hospital and a daily rate is set.

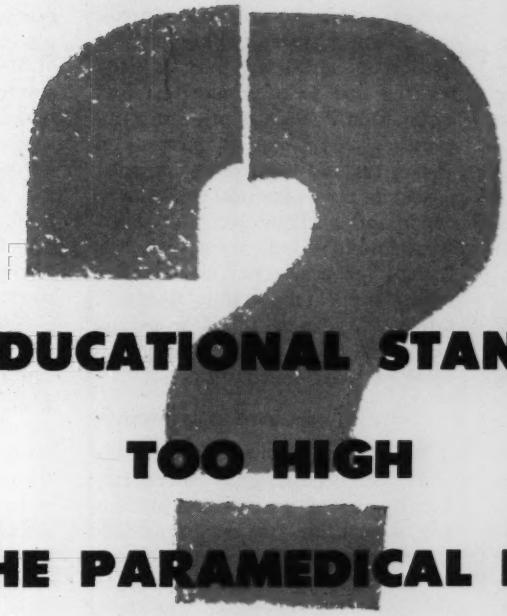
Only patients who pay full rate ($15 per day in a semiprivate room and $19 in a private room) are accepted as private patients. All others are service patients, under the direct care of the medical director and his staff. As a general policy, patients who pay full rate remain private patients. Exceptions are made only in unusual situations and only with the full consent of the referring physician. If private patients, after admission to the chronic disease division, request change to service status, they are told to discuss this with their private physicians first. If a physician agrees, he will contact the medical director and request the change in status.

In urgent situations the medical director may admit a patient immediately and financial arrangements are made later on.

If a patient is rejected, the family is referred to the social worker who will assist them in working out an alternate plan. This referral blunts the shock of rejection. It helps the family understand why the patient is not eligible and it indicates to them that the hospital is still interested in their problem and is willing to help. Some patients have been referred to the home care department for further care. In other cases the social worker will help the family in selecting a suitable nursing home.

Approximately one out of ten applications is rejected. Not every

(Continued on page 49)



ARE EDUCATIONAL STANDARDS TOO HIGH IN THE PARAMEDICAL FIELDS

by NATHAN BUSHNELL III

The high educational requirements of many paramedical groups are contributing to the personnel shortage facing the health field, the author contends. He cites examples that buttress this position and suggests an approach which he feels provides a more practical solution to the personnel shortage.

ALTHOUGH a strong exponent of education in every form, I am convinced that the majority of paramedical groups have raised their educational sights too high. By their insistance on constantly elevating the standards of their schools and the requirements for registration by national societies, these groups are paradoxically perpetuating the personnel shortages they are trying to overcome.

It is a natural desire of paramedical groups to try to elevate the professional stature of their members. This is understandable and commendable. Somehow, however, these groups should be persuaded to slow down—at least temporarily—their aspirations and supply practical, immediate solutions to patient care problems.

A college degree is undoubtedly valuable in almost any career. If the proponents of degree programs in all the health fields are successful, however, we can forget about overcoming personnel shortages in the near future. We'll have to close our ears to the demands of neglected patients while we wait for graduation day.

Nathan Bushnell III is administrator, Franklin Memorial Hospital, Rocky Mount, Va.

This material is adapted from a speech presented at the first recruitment workshop of the American Occupational Therapy Association, Richmond, Va., May 1958.

UNBECOMING HOSTILITY

Let me be more specific. Just as one doesn't have to be a mechanical engineer to drive an automobile, a woman does not require a "B.S." or even an "R.N." after her name to make beds, give back rubs, tote bedpans, and the host of other duties which were formerly the domain of the professional nurse. Recently, hospitals have discovered that these duties can be performed most satisfactorily by people with less than three years training—and the practical nurse and the nursing aide have taken their places on the health team.

This was not accomplished without protest from some professional nurses who apparently felt the dignity of their profession had been attacked. Unfortunately there are still numerous "old guard" graduates who retain an unbecoming hostility toward ancillary nursing personnel when, more properly, they should regard them as partners.

The same groups which maintain that no one can give bedside nursing except professional nurses continue to raise the standards for schools and pupils, requiring more and more didactic and less and less practical patient care training. Such training is producing fine young women with good educations; but there are not enough of them to meet the demands. Because of practical necessity as well as economic prudence, therefore, the practical nurse and the aide have become accepted as essential members of the team.

There is much to be said, of course, for the rebuttal that contends the constantly expanding technological advances in paramedical fields require extensive training. I maintain, however, that there are numerous aspects of every medical and paramedical field which can be efficiently handled by persons with minimum schooling or on-the-job training. For example, practically any high school student can be taught the mechanics of a urinalysis or a

blood count—and these two procedures comprise from 50 to 75 per cent of the work done in the average laboratory. Such assistants certainly could gather specimens and wash glassware, thus enabling the well-trained technician to spend her time performing complex procedures and supervising the assistants. Can you imagine a more expensive and flagrant waste of manpower than sending a girl through three or four years of accredited laboratory schooling and then requiring her to spend 25 per cent of her time as a dishwasher? Yet this is exactly what is going on all over the country.

This same type of practical assistance could be profitably employed in many paramedical groups. Let's take a look at occupational therapy, for example, using material published by the American Occupational Therapy Association to present the case.

In the AOTA recruitment pamphlet, *Play on the Recovery Team—Be an Occupational Therapist,* the illustrations show: a leather lacing project, playing ball, evaluation of hand dexterity, sandpapering, observation of a typesetter, adjustment of simple equipment, observation and participation in a children's party, teaching the use of a typewriter, and instruction in the use of a grasping prosthesis. In my judgment, a highly trained registered therapist would be most essential to evaluate needs and perhaps give initial instruction to all of these patients. Except for occasional observation, follow up, and further analysis, however, why couldn't a person with far less training carry out most of these mechanics?

AN IMPOSSIBLE PROBLEM

This is not meant to belittle the work of occupational therapists. Far from it. I am merely probing for a solution to an impossible problem which is posed by another AOTA publication, *Facts—about Occupational Therapy.* The facts show there were 5,583 registered occupational therapists as of March 1958. Projected need in 1960, just 2 years hence, will be 10,000 additional, or a total of approximately 16,000. To close the gap, 490 occupational therapists were graduated in 1957 from 29 approved schools. Using round figures of 500 graduates per year and assuming there will never be a demand for more than 16,000 and assuming none of the present therapists will retire, die, marry, or for any other reason leave the field, it would require something like 20 years to fill current needs using methods and facilities now prevailing.

Situations as serious as this in most paramedical fields justify my theorem. Short-term training programs for practical assistants should be developed in all our paramedical groups. Numerous hospitals have resorted to this plan with excellent results. National paramedical organizations should now seize the initiative and expand the idea. They should encourage this type of training by establishing a curriculum and providing basic textbooks. In my judgment, such planning offers about the only solution to our shortages which would result in prompt relief. ■

ASSEMBLING AN ASSEMBLY

IT TAKES a lot of people—a lot of coffee—and a lot of time to plan the New England Hospital Assembly session. Here is the program planning group in a recent session going over last minute details for the 1959 meetings scheduled for March 23-25 at the Statler-Hilton Hotel, Boston. Chairman of the program committee, Dr. Philip D. Bonnet, administrator, Massachusetts Memorial Hospitals, Boston, is at head of table (left).

These questions, facts and statistics are

WHAT THE PLANNER HAS TO WORK WITH

by ANTHONY J. J. ROURKE, M.D.

Determining the number and type of hospital beds needed in a community is at best an educated guess, states the author. He outlines factors which should influence these "guesses" and discusses other areas to be considered in planning community health facilities.

IN PLANNING the health facilities necessary for a community, first consideration is generally given to determining the number of hospital beds needed. How is this done?

The formula sounds simple enough: Beds needed will depend on (1) the number of people admitted to them, and (2) the length of time these people stay.

But, how do you know how many people will be admitted annually to the community's hospital beds? This will depend upon many factors:

1. What is the population of the hospital service area?

2. What is the ratio of admission per thousand population? Is it 50, 100, 150, or 200?

3. What is the per capita income of the area? Can the people afford hospitalization?

4. How prevalent are hospital insurance and prepayment plans and how do they facilitate necessary hospital admissions or stimulate unnecessary admissions?

5. What is the educational level of the area—backwoods, grade school or higher?

6. What is the age distribution in the community?

7. How close are larger metropolitan hospitals which are associated with medical schools?

8. Are outpatient services available and included in prepayment insurance and plans?

9. What percentage of the population is made up of veterans who seek their hospital care in near or distant government hospitals?

10. Is the number of skilled physicians adequate for the area?

11. What is the age of the community hospital? Is it too new to have been generally accepted?

12. What is the pattern of medical practice? Are house calls made at night or are patients sent to the hospital for emergency care by the resident?

13. Are all teeth extractions done at the hospital?

14. What are the quality and activity of the local and state public health departments?

15. Has the industrial health program been developed at optimum levels?

DETERMINING LENGTH OF STAY

After determining roughly the numbers of admissions per year, the next question to answer becomes: How long will the patients stay in hospital beds? This, too, depends on many factors:

1. Are patients admitted for short diagnostic stays to circumvent the shortcomings in prepayment policies which do not pay for ambulatory diagnostic work?

2. Are beds scarce, and is turnover speeded up by the law of supply and demand?

3. Are beds available in surplus numbers and does the policy of "tomorrow is good enough" control the speed of diagnostic and therapeutic procedures?

4. Do the hospitals have the beds but not the corresponding quantities of supporting services and facilities, resulting in bottlenecks of delay waiting for operating rooms, anesthetist's time, laboratory and x-ray services and reports, or the discharging visit of the specialist?

5. Does the medical staff control itself and recommend privileges on the basis of training and ability?

6. Does the staff avail itself of consultation services which may affect the length of stay?

7. Is the hospital on a five-day week, with surgery, x-ray and laboratory Saturday and Sunday ghost towns?

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8. Are nursing homes, convalescent units and long-term care beds available in or out of the hospital?

9. How many of the beds are in teaching services which may affect length of stay?

10. What effect does multiple insurance coverage have in determining duration of hospitalization?

11. Does the community have an organized home medical care program to facilitate early discharge or to obviate the need for certain hospital admissions?

At this stage, those planning hospitals are probably impressed with the many ifs, ands, and buts that must be considered in determining bed needs. For instance, when one combs the literature for the formulas, the following commonly used methods will be found:

1. Admission rates per 1,000 population.
2. Average daily hospital census per 1,000 population.
3. Bed-death ratio.
4. Bed-birth ratio.
5. Age group utilization.
6. Federal government estimates.
7. State and municipal estimates.
8. Local utilization experience.

Once a planner has set up his algebraic equation he must convert letters to numbers and this is where he will soon be convinced that determining bed needs is, at best, an educated guess. Letters in the equation frequently become estimated numbers. Let us look at some areas of estimation:

1. Even populations must be estimated because of the delay in census reporting and the 10-year span.

2. Since most studies involve circumscribed areas, one often is compelled to estimate the number of people who left the area to get hospital care elsewhere.

3. In marginal, populated places separating two hospital service areas, some estimate of population must be used for each service area, since hospital admissions tend to go in both directions.

4. Out-migration and in-migration for hospital care are estimates.

The planner is also faced with certain facts that usually are not determined in a bed need survey because of cost, such as

1. Pattern of medical practice.
2. Sufficiency of hospital service.
3. Types of prepayment insurance coverages.
4. Degree of community health consciousness.
5. Success of health education.

ONLY CHANGE IS CONSTANT

At this point, the community health planner will be faced not only with the arithmetical intricacies of determining bed needs, but he must also add another factor called changing trends. For example:

- Tuberculosis death rates have dropped from 45.2 per 100,000 population in 1939 to 9.5 per 100,000 in 1955.
- Syphilis death rates have dropped from 11.2 per 100,000 population in 1939 to 2.3 per 100,000 in 1955.
- Cancer deaths have increased from 118.3 per 100,000 in 1939 to 147.6 in 1955.
- In 1956 and 1957, for the first time in history, there was a reduction from the previous year in the number of resident patients in mental hospitals.
- Of live births in the United States, 37 per cent occurred in hospitals in 1935 while 93 per cent occurred in hospitals in 1953.
- During the same period, maternal death rates dropped from 58.2 per 10,000 live births in 1935 to 6.1 in 1953.
- The need for pediatric beds has not followed the trend shown in the need for seats in school rooms.
- Some hospitals have seen 75 to 85 per cent of their patients' bills paid by some form of prepayment by third parties, where none existed 30 years ago.
- The Joint Commission on Accreditation of Hospitals has greatly upgraded medical care in hospitals and at the same time has created need for more x-ray and laboratory space, more record room space, more autopsy space, more meeting room space and more trained people.
- Seven-day split shifts have fortunately given way to five-day straight shifts.
- We are finding in our medical audit work that the extraction of teeth in many communities is being transferred entirely from dental offices to hospitals. We hope that soon a combined committee of the American Medical Association and the American Dental Association will review and evaluate this shift.

Change seems to be the steady plan of hospital life. We may now have a surplus of beds for patients needing care for tuberculosis. Conversely, however, beds in many areas are scarce for those needing long-term care. The planner needs to ask himself what percentages of operating room time, x-ray activities, laboratory procedures, and bed care are consumed in diagnosing and treating patients with cancer? What would happen if cancer were to join the conquered enemies such as typhoid fever, diphtheria, smallpox and typhus?

These changing trends should be expected to continue and it is the moral responsibility for each of us to build for flexibility. The isolated tuberculosis sanatarium, and possibly surplus psychiatric beds, may lack the necessary flexibility to quickly change to other uses. Bizarre planning of many unorthodox units within the general hospital may live to haunt us.

EGGS IN TOO MANY BASKETS

Every planner knows the heartache of trying to hammer out a better future for the community on the anvil of tradition, vested interest, personal prejudice, pride of ownership, and conflicting interest. However, heartaches are no reason for not trying. Our American hospital communities have grown without rhyme or reason, except for the nationalistic spirit which immigrated from the old world.

This helter-skelter plan has left many of our larger communities carrying eggs in too many baskets. Teaching opportunities for interns, residents and nurses are found in too small numbers in too many hospitals. Equipment is duplicated and physicians' time is dissipated in unnecessary travel. New wings are frequently added to old buildings which should be abandoned. Uneconomical floor heights are duplicated in the newer structure or unreasonable ramping is followed so that an unwise hospi-

tal operation may be continued.

The sponsors of the multiple-small-hospital community champion the virtue of competition or distance. I fail to see these as virtues. The competition more often appears to resolve itself into pirating personnel or duplicating expensive equipment, in order to keep pace with one another. There is no competition in the quality of medical care, and frequently the same doctor will treat patients on the same day in two or more hospitals. With improved transportation, distance is no longer a major factor in requiring multiple hospitals.

In my opinion, then, no modern planner can consider multiple small hospitals an asset to the community. Accepting the necessity of respecting religious groups in the operation of their hospitals, I believe that every effort should be made to urge independent community hospitals not operated by religious groups to merge in future planning, so that, as soon as possible, in large towns and cities, no general hospital will be less than 200 beds; and no specialty hospitals will be independently operated.

The history of the Hill-Burton program and the state agencies administering it in most areas are a tribute to the ability of government and its citizens to join forces to improve the lot of our people.

Federal money has provided the impetus to improve hospitals at a very fast pace. The program focused the attention of the states on their existing hospitals and then whetted their imaginations on what they might be like.

The need for federal support will probably exist for many years as a factor in hospital planning.

NOT BY GENERAL CARE ALONE

Needless to say, the community planner must look beyond the general-care, short-term beds to complete the picture. Health needs are not met by general care beds alone. General hospitals are called on to provide facilities for more and more varied activities. He should remember that patients in separate tuberculosis hospitals have been decreasing sharply and that the census in mental hospitals has been decreasing slightly for two years. Concurrently he should remember that both tuberculosis and mental illness are being successfully treated within the general hospital.

Where long-term care beds should be built is the subject of some discussion. Few, however, deny the need for them. I believe that close proximity to the services of skilled people and excellent diagnostic and therapeutic equipment should place beds for convalescent and chronic care attached to or very near the general hospital.

World War II opened up new vistas in the field of rehabilitation. No alert planner should overlook this trend. Another trend toward locating doctors' office buildings at or close to the general hospital also deserves attention.

Time and again planners have seen new special units fail to succeed because trained people were not available. At other times, superb programs seem to thrive in deplorable facilities because well-trained dedicated people were giving leadership.

No community should be content with bricks and mortar, black top driveways and modern lobby shops. Each has its place, but unless a continuous stream of trained people keeps pouring out of our supply line we will fail to achieve our goal. Education and research have special program and facility needs which should be considered in community planning but cannot be met by every hospital.

We need people with training and imagination to do research in new and better methods. We must refocus some of our attention from overemphasis on hospital beds to more emphasis on maintaining health through disease prevention and health education.

Surveying the community for tomorrows' health needs is a challenging and interesting activity. When the principals are harnessed together and pulling in one direction, there is no limit to their achievements. The planner who forgets the existence of and the need for cooperation of a public, a board, a medical staff, nurses, dietitians, social workers, and paramedical groups, patients, and anxious relatives will soon realize the need for team work. ■

Short Cuts to Confusion

Although an abbreviation may be clear to the writer, it is often obscure to the reader. For instance, a music therapy department has an "instrumental combination for ward playing" which they call a "ward combo." This is abbreviated, to "W.C." The first time the new director saw a memo headed "W.C.," he referred it to the engineering office.

The Veterans Administration hospitals call a furlough a "trial visit," which they abbreviate "T.V." New employees are startled at inquiries about how many patients are on TV. The Veterans Administration also uses the symbols "AMA" on an ex-patient's chart. In this case AMA does not mean American Medical Association. It means that the patient left the hospital against medical advice.

I once saw a memo from a ward which stated that a patient had sprained his ankle, and the nurse had applied B.S. to the skin. Intrigued by this, I inquired, to find out that B.S. meant Burow's Solution, and not, as I originally thought, "breath sounds," or maybe "bachelor of science."

Even such a simple abbreviation as the letter "O" means "pint" to the pharmacist, "oxygen" to the chemist, a blood group to the hematologist, and "eye" to the ophthalmologist.

A good rule for clear communication is: avoid abbreviations. You may be sure that "P.A." means "paralysis agitans," but the ward doctor may read it as "pernicious anemia." HENRY A. DAVIDSON, M.D., *superintendent and medical director, Essex County Overbrook Hospital, Cedar Grove, N.J.* ■

This care now, pay later billing system tells the patient

'IT WAS A PLEASURE TO

by CHARLES J. HACKETT and MARTIN S. ULAN

What seemed to be a credit system at this hospital was actually, according to the authors, a "cash-in-advance of the cash" system that resulted in dollar losses and bad public relations. The authors describe the experiments and thinking that helped the hospital correct this situation by instituting an up-to-date credit policy.

FOR A NUMBER of years we tried to cope with late charges. We tried every trick of the trade and still we were unable to eliminate these recurring nuisances—or cut down the losses they caused.

We used multi-part forms and triplicate charge tickets. We developed intricate discharge slips and asked our nurses to list the medications, supplies, and diagnostic services which the patient received during the final hours of his stay. We emphasized the necessity for getting charge tickets down promptly and we wore out our personnel with our insistence that all other problems must be subordinated to this one. We prompted the physicians to give us 24-hour notice of discharge and we kept experimenting with the discharge hour in order to give our business office as much time as possible to prepare a final bill. We even considered the installation of a facsimile message transfer system to provide instantaneous notice to the business office.

Still we had late charges, mounting losses, and the perpetual embarrassment of having to send out supplemental statements and follow-up letters only to receive in return the protestations of the patient that his account had been settled at the time he left the hospital.

Some of the replies we received started off with such colorful questions as, *What's the matter with you people?* We thought we'd find out. Possibly the late charges were not a cause—perhaps they were a result.

It was easy to understand that if a person bought a vacuum

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cleaner and paid for it before he left the store, he didn't want to be told the following day that he owed another $16 on it. And he didn't want to be told the day after, that he'd have to pay another $4 because someone just learned that the machine had a special attachment for picking up old razor blades.

It was equally easy to understand that since consumer credit throughout the country has passed the $40 billion mark and that since more and more of the business of the nation is being run on credit, possibly the country's fifth largest business, the hospital business, might also be run on credit. It seemed incongruous that credit can be extended for motor cars, refrigerators and television sets but not for such necessities of life as hospitalization. Nor is consumer credit entirely composed of luxury items. Food and clothing, which are certainly no more essential to life than hospitalization, are purchased in ever-increasing quantities without cash. Furthermore, buyers must be paying their bills because the sellers report profits.

But hospitalization is something a person doesn't want, we were told. We examined this statement and found that many of the things a person buys on credit are equally unwanted. Still they are necessary and they have to be paid for. A man with six children doesn't relish the idea of buying six pairs of shoes every couple of months but he has to do it. A man who needs a car to get to work has to buy a new car when the old one wears out.

But, we were warned, *the places which sell articles like those have the means of collecting their money from the people who try to avoid payment.* True, but maybe we could avail ourselves of a similar means of securing payment and at the same time eliminate late charges, buy the best and cheapest public relations in the world, run a more efficient business operation, and do away with the unpleasantness which the presentation of an improperly prepared bill always creates.

Our brochures stated at that time that we had a credit manager and a credit policy. The credit manager, however, was little more than another collector and our credit policy, paradoxically enough, was designed to function at its best when there were no credit risks. We said in effect, *Your credit is good just as long as you don't use it.* So we offered it—liberally to those who didn't need it; grudgingly to those who did. And, as a matter of policy, we tried to pry some cash from everyone who left the hospital especially those who looked as if they didn't have any.

SERVE YOU'

CASH BEFORE AND AFTER

In those instances where the credit manager did extend credit and the patients didn't pay, we were quick to emphasize her woeful lack of judgment. To protect herself the credit manager asked for more and more cash and extended less and less credit until finally our credit plan was operating on an "all-cash" basis. This, however, fitted in nicely with our general procedure because at that time we were asking for an advance deposit. While we claimed to have a credit system we were actually on a "cash-in-advance of the cash" system.

Since there was no point in asking for cash all day and failing to do so at night, we had a night cashier who made sure that no one slipped by after the close of normal business hours. After the night cashier left, the night supervisor took over the till whenever there was need for it. The same was true on weekends. No one got out without paying—except the ones who couldn't pay and the ones who wouldn't pay. Some of the latter used to tell us that they thought the deposit represented full payment of the bill. Some felt that it entitled them to set their own terms and their own time for payment of the balance. After all, the purpose of the deposit was to establish responsibility. Since the person established his by prepaying $100 we couldn't very well question his intent, his ability or his willingness to pay the balance.

Where a patient left the hospital before his deposit was used up, we were faced with the need for issuing refund checks and a good many people wanted their refunds as they left. Not because they didn't trust us but because they needed the money. After all, we had wanted ours in a hurry. For our purposes, it began to look as if the cash deposit was not the answer to anything. Certainly, it had been getting more and more difficult to get $100 from someone who didn't know when he went out for the evening paper that he was going to collide with someone else who didn't have $100 either.

NO REGRETS

It was then that we decided to adopt a credit policy; an honest-to-goodness, worthwhile, well-constructed, dynamic, up-to-the-minute credit policy. That was two and a half years ago and we have never regretted it.

Realizing that we'd have to do it in stages, we first abolished the advance deposit. Then we wrote up a detailed guidance so that the registration office would know exactly how to classify each patient. We stated in our guidance that classification of a patient was a prerogative of the administration (not the physician) and that it would be carried out solely by the registration office. After the patient was admitted, recommendation for transfer from private to ward status and the converse might be made by the credit manager or the social service director, after consultation with the physician. Responsibility for putting the patient in the accommodation which he could afford, however, rested with the registration officers. We explained to them fully and precisely how to classify patients who

had Blue Cross, group insurance, compensation insurance, private insurance, liability insurance and no insurance.

We then put our business office on a five-day, 40 hour week. As a tentative approach to our projected change in billing procedure, we installed a sign which told our patients that after 4:30 and on weekends their bills would be mailed. Then we stood back with our hands over our ears. Nothing happened, at least nothing of an untoward nature. So we moved ahead with our plan. We joined the local credit bureau and arranged to have our delinquent accounts handled the way other businesses handled theirs. After all, the credit bureau had several million names in file and would certainly be in the best position to know how much and how fast a person could pay. Then too the bureau had knowledge of suits and judgements and this avoided the unhappy prospect of our adding another judgement which would long since be rendered ineffective by the statute of limitations before the prior suits were satisfied. In addition, by using the credit bureau, we could get credit information whenever we needed it.

NO BEDSIDE MANNER

The next thing we did was to divorce business operations from the nursing areas and permit the credit manager to transact business only with a member of the patient's family. Even where the patient wanted the bill sent to his bedside we refused, suggesting instead that it would be better to let a member of his family take care of financial matters for him. The credit manager was then able to concentrate on preventive measures rather than remedial measures and to devote more time to credit evaluation than to collection procedure.

We found that about 65 per cent of our admissions were covered either by group insurance plans or Blue Cross. We asked the credit manager, therefore, to spend the major part of her efforts on the 35 per cent who were not covered by third party insurances. Since out of the 35 per cent remaining, at least 15 per cent were ward cases (payment for which was usually arranged by the social service department) the percentage of patients with which the credit manager had to be concerned was reduced to 20 per cent. After watching the matter closely we soon learned that approximately 10 per cent were so situated economically that they had no great need for hospitalization insurance. These people were able to pay their bills promptly. This left only about 10 per cent of our patients whose credit might become a matter of concern.

GOODBY FOREVER

Rather than hold up the 90 per cent for the 10 per cent, we discontinued the practice of giving bills to patients at the time of discharge. We placed a public relations-minded young lady at the cashier's window who said to the departing patient, *It was a pleasure to serve you, your bill will be mailed.* In saying this we said good-by forever to late charges, arguments at the cashier's window, hurriedly prepared and incorrect bills, extra office personnel, overtime, insurance mix-ups, and a number of assorted administrative headaches.

This move naturally increased our accounts receivable but we did not feel that this in itself was a catastrophe. For years we had used the rule of thumb which stipulates that accounts outstanding should not exceed one month's billing. But then we remembered that consumer credit was increasing by $307 million a month and that a good many of the old concepts concerning accounts receivable were being revised. Then too, while we did not ask for payment until a final, total, accurate bill could be presented, we in no way implied that we were apathetic about our money. On the contrary, we wanted it promptly and we were now able to get it by pointing out that we had been thoughtful and cooperative, that we had not delayed or embarrassed the patient at discharge and that we expected payment "upon presentation of the bill."

For years the community had wanted us to operate "in a business-like way" and now we were doing just that. If the bill was not paid promptly, followups were initiated at once. After a series of carefully worded letters, a final note was sent out. If the account was still not settled, a phone call was made. If this brought no results the account was on its way to the collection bureau by the fifteenth of the following month.

We are obliged to pay collection fees, of course, but they are only a percentage of the amount collected so it is a matter of great interest to the credit bureau to pursue vigorous policies of collection. Since the credit bureau is a nonprofit organization run by its

under

Construction of the first burn therapy center in the Midwest began this month in Milwaukee at St. Mary's Hospital. The Electric Company authorized funds for development of this intensive care unit devoted to the treatment of burn cases.

Planning for the burn therapy center was begun in the spring of 1958. Dr. John T. Klein, who heads the medical activities at the Electric Company and who is a member of St. Mary's staff, suggested consideration of this type of service to both the hospital and the company.

It is expected the burn therapy center will also serve patients outside the immediate Milwaukee area. Dr. Klein reports that even serious burn cases can be moved a considerable distance the day of the injury.

Once in the unit, the burn patient is assured the attention of a medical and nursing burn team which will have the very latest in equipment at their disposal. The

members, we have a voice in the formation of policy. We retain the right to pass on all collection literature before it is sent out. We also reserve the right to final disposition of any account. If our social service department finds after a delinquent account has been turned over to the bureau that a more lenient course of action is indicated, we merely request return of that account and there is no charge to us. In the event that we authorize a lawsuit, the credit bureau institutes proceedings in its own name so that our name does not appear on the public records. In addition, the credit bureau keeps a permanent record of amounts owed to the hospital so that if at a later date someone in the community applies for consumer credit, he is turned down until he settles his hospital obligation.

SYMPTOMS DISAPPEAR

Two of the greatest benefits which accrued to us almost immediately were the acquisition of public relations at practically no cost and the improvement of our own personnel morale through the elimination of the abrasive contacts which used to be part of the business office day. Naturally the late charge disappeared very early in the reorganization because as we suspected it was a result and not a cause of our procedural weakness. In other words, it was a symptom of illness and not the actual illness itself.

Now if a patient or a member of his family wishes to discuss a bill, we are more than happy to do so, preferably by mail or by means of a personal visit after discharge. The spontaneous misunderstandings which used to arise at the cashier's window have been given no opportunity to be rekindled.

The new procedure is equally welcome to our nurses because they no longer have to notify the business office of discharges or sacrifice nursing time to business procedures or wait at the cashier's window with a patient in a wheel chair while someone computes the patient's share of a complex insurance plan. The business office personnel are pleased because they no longer have to act as house detectives or drop other work to post an account and prepare a bill each time a patient goes home.

Naturally the patient is happiest of all because the Golden Rule is as much in force when he leaves as it was when he entered.

In addition to these intrinsic benefits, the installation of a bona fide credit system has permitted us to compete with industry in securing employees because we now offer a five-day, 40-hour week with no overtime.

Yet the system is neither a philanthropic gesture nor a gamble. It is a practical and efficient means of getting a correct and final bill to the patient so that he in turn will be able to pay us more quickly. And, he does just that. Our outstanding receivables are now far less than the one-month billing we used to count on. Our current loss on bad accounts is considerably less than that of a finance company. On stays of longer than seven days we expect as heretofore that each week's bill will be settled as it is presented (unless credit terms are applied for at the time of admission). The bill is mailed home, however, and no patient ever finds a bill under his pillow or waiting for him on his bedside table.

NOT SUBSCRIBING TO FICTION

Administratively we do not feel that the procedure is the final answer to business office management. In a field as dynamic as that of hospitalization, static processes are no longer acceptable and newer and better methods must be sought if we are to provide the best care and service possible. We do feel that we must continue to find ways of helping our patients pay for their hospital services and the only solution is the constant improvement of a realistic credit policy and the adoption of practices which are being used in other businesses.

We will not for a moment, though, subscribe to the fiction that a hospital must be run as a business. The aim of a business is to make profits. The aim of a hospital is to take care of the sick. We no longer want to encourage the attitude, however, which begged for the public's patience and forbearance on the grounds that the hospital was doing its best in the face of enormous difficulties.

Rather we want to adopt the attitude of a manufacturer when he says, "This is the finest product money can buy." The fact that his product which now sells for $3000 could be purchased 25 years ago for $685 causes him no chagrin at all. Nor does he care whether his product is considered a luxury or a necessity. He's there to do exactly what he promises—provide the best product possible and make it easier for people to pay for it. Can hospitals afford to do less? ■

BURN THERAPY CENTER

construction in Milwaukee

patient will also be admitted to a carefully designed intensive care area where every phase of his care can be attended to with a minimum of discomfort or delay.

St. Mary's burn therapy center will occupy an area on the east wing of the fifth floor of the present building. This space will be extensively equipped to make a completely isolated unit subdivided into five areas: a primary treatment unit as well as space for four patients. As usage of the center increases, the design of this unit will allow it to continue as the center of operations with its bed space used for the most critical patients.

The unit will be available to burned patients regardless of staff affiliation of their doctor. It is expected that the center will be ready to accept patients in May. Upon completion, the burn therapy center at St. Mary's Hospital will be the third such unit in civilian hospitals. Others are in Richmond Va., and San Francisco. ■

This study shows

WHO REALLY USES THE NURSE-PATIENT

by JOHN D. THOMPSON, JOHN F. O'CONNOR and HUGH J. MAHER

The authors describe a study which disclosed that the audible "nurses' call" system actually functioned mainly as a communication system for personnel on the unit. The methodology of the study and the implications the study results may have in hospital and equipment planning are also discussed.

FOR MANY YEARS various levels of staff within the hospital have been demanding better systems of communication between the patient and nurse. The nurse's call bell served its function well, as did the buzzer and light systems.[1] The advent of voice communication, however, resulted in new concepts of nurses' call systems.

The first such system consisted of a bedside microphone that could transmit the patient's voice to the nurses' station. It was a clumsy apparatus that never quite assured the patient that his needs were made known. Complete voice intercommunication systems that have become a permanent part of the modern businessman's office were, therefore, explored. Could such systems be adapted economically for use within the hospital to give the patient a unique contact with service personnel? Electronic and telephone companies began to experiment with office systems and to develop a variety of units that could be utilized within the hospital.

The Reading Hospital of Pennsylvania was one of the first to incorporate the system into their nursing units. They reported it was a valuable and economical means of providing better patient care.[2, 3] Some 4000 calls from the patient were analyzed. Of these, more than half were requests for specific articles not in the patient's room. The nurse, being forewarned, could bring the article to the room, thus saving time and steps. St. Luke's Hospital in Cleveland and many military hospitals reported similar experiences with the system. These reports pointed out other advantages, such as a greater assurance to the patient, less traffic, noise and confusion in hospital corridors, and ultimately better patient care.

A University of Pittsburgh study[4] was the first to mention the use of the system as a means of staff communication. Members of the study team of the Yale Project in Function and Design also noted the frequent staff use of the system in the course of observations made in two previous studies.

One of these, a study of the inpatient unit, indicated that the nurses' station is the most important single facility within this unit, as measured by personnel traffic and personnel time within a specific area. The location of the nurses' station, then, is most critical in the design of the inpatient unit. Nurses themselves felt that the nurses' station should be (1) placed in a position in the center of the inpatient unit; (2) located so as to control all traffic in and out of the unit; and (3) situated so that the entire length of the unit corridor is visible from the "control" desk of the station.

Why were the nurses so concerned about seeing the door of every patient's room, as long as the room numbers lit up on the master station of the voice intercom at the "control" desk when a patient desired a nurse? The answer was that "the full view" was as much for personnel location as it was for patient supervision. A complete corridor view gave the nurses and ward secretaries an idea of just where the staff was, so they could contact them by the nurses' call system.

TWO PLACES AT ONCE

The necessity for such staff communication becomes obvious after considering the original purpose of the voice intercommunication system. It was designed solely as a patient-nurse call system. Two rather basic suppositions were made for the system to operate efficiently and to the patients' satisfaction. The first was that there would always be someone, usually a nurse, at the master station ready to answer the patient's call; and, the second, that this per-

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COMMUNICATION SYSTEM

son could then perform the requested service. These two basic assumptions were not usually compatible. If an individual was to perform a requested service, it was obvious that she could not remain in the nurses' station to answer calls.

The responsibility of answering the calls, at least during the busy part of the day, was then assigned to a specific person (usually the ward clerk or secretary) while another person performed the requested services. Communication between these two individuals then became necessary so the patient's request could be transferred to the person who would perform the service. The "nurses' call" system was used for this purpose. In addition, the call system was used to locate or page hospital personnel and staff for reasons having nothing to do with patients' requests.

The second observation that staff were using the system was made during a patient interview study. The purpose of one of the questions was to determine how the patients felt about the nurses' call system. Patients, on the whole, rated the system as very satisfactory. There were some reservations, however, especially by the patients in the higher social classes. The patient complaints generally referred either directly or indirectly to the call system's use as a personnel locating or paging system.

It was evident, then, from these two observations that the staff was using the system rather frequently for reasons completely divorced from its theoretical purpose. A hypothesis was formulated that the audible nurses' call system was (1) misnamed, and (2) poorly designed, since it actually functioned, not as a nurses' call system, but as a communication system for everyone on the floor—staff and patients.

INTERCOMMUNICATION SYSTEM TAPPED

This hypothesis was tested at the Memorial Unit of Grace New Haven Hospital where a concealed* tape recorder was attached to the voice intercommunication system during those hours when it was felt there was a likelihood of someone's being present at the nurses' station. These 15½ hours from 7:30 a.m. to 10 p.m. are referred to in the study as "day observations." During the late evening and night hours, an observer was stationed on the floor to note each use of the system. This 8½-hour period from 10 p.m. to 7:30 a.m. is called the "night observation period." The basic unit of measurement used in the study was a "call." A call is defined as each instance in which a person at one station transmitted a verbal message to another station and it includes answers or discussion, if any, relative to the message.

Through analysis of the tapes and observation notes, an attempt was made to answer the following questions:

1. Who initiated the call?
2. If initiated by a patient, how long before it was answered?
3. By whom was the call answered?
4. What was the purpose of the call?
5. Was the call unanswered?
6. If unanswered, was it repeated? How often?
7. What features were undesirable in the system studied?
8. What additional features were needed in the system?

The study was carried out on a standard audio-visual nurses' call system installed in the laboratory hospital. The system is essentially the traditional bell and light nurses' call with the added feature of two-way voice communication. The patient can initiate two-way voice intercommunication with the master unit at the nurses' station by pressing his "call bell." At the same time, the "visual" part of the system is activated. A light goes on over the patient's door and the room number is illuminated at the master station. Staff at the master station can then answer the patient and cancel the call either from the master station or the patient's bedside. Staff at this master unit can also initiate a call by pressing a location button and speak to, or listen to, anyone in the patients' rooms. Sub-stations are also situated in utility rooms, pantries and corridors. These stations, although indicating a patient call by a light, could communicate only with the master station. One paging speaker was placed in the corridor of each wing of the unit.

Four inpatient nursing units were chosen for this study. All were V-shaped, with the nurses' station, the utility room, and drug closet at the base of the V. Each arm of the V contained a corridor with patient rooms on both sides. Each floor of the hospital contained two of these V-shaped nursing units placed back to back to form an "X." At the intersection of the X, between the backs of the two nurse's stations, were located staff and visitors' elevators, lobbies, solaria, diet kitchens and various administrative and educa-

*The tape recording technique was outlined to nurses at a meeting a few months before the study was undertaken. The nurses knew tapes would be taken, but they did not know when they were taken.

tional rooms. The differences in the four individual nursing units were:

1. The surgical west unit contained 30 beds: 26 single-bed rooms and 2 two-bed rooms.
2. The medical west unit contained 28 beds, all in single rooms.
3. The surgical east unit contained 48 beds: 11 four-bed rooms and 4 single-bed rooms.
4. The medical east unit contained 48 beds: 11 four-bed rooms and 4 single-bed rooms.

DIFFERENCE BETWEEN DAY AND NIGHT

There was, as would be expected, a radical difference in the pattern and frequency of calls between day and night (Fig. 1, right). Day activity was about three times as great as night activity. This pattern did not vary a great deal, however, between the units studied, even though the size of the unit and the type of treatment the patient was receiving differed. The study did not, then, measure a single unit with all the dangers of peculiarity such a study might contain, but was able to analyze a rather constant pattern of usage on four different inpatient units.

The most important observation here is that the staff initiated more calls on the system than did the patients during the day hours, the time of heaviest activity. The opposite was true only at night.

The first part of the hypothesis, then, seems to be true: during the most active periods, the voice intercommunication system did not function mainly as a nurses' call system, but as a staff communication system.

Fig. 1—Percentage of calls

	DAY (7:30 a.m. to 10 p.m.)			NIGHT (10 p.m. to 7:30 a.m.)		
	PERCENTAGE OF CALLS		CALLS	PERCENTAGE OF CALLS		CALLS
	Initiated by staff	Initiated by patients		Initiated by staff	Initiated by patients	
Surgical West Capacity 30 Census 27	68	32	567	28	72	32
Medical West Capacity 28 Census 26	61	39	303	12	88	50
Surgical East Capacity 48 Census 44	68	32	593	7	93	106
Medical East Capacity 48 Census 42	73	27	604	9	91	55
All Units	68	32	2,067	11	89	243

PATIENT INITIATED CALLS

Was the voice intercommunication system designed to function efficiently as a staff communication system, as well as a nurses' call system? Analysis of the more familiar patient initiated nurse call function will be considered first in attempting to answer this question. Of all calls from the patient, during the day approximately 90 per cent were answered by the ward clerk. This is significant. As was mentioned above, the clerk answered the patients' calls, but she could not perform the services requested in most instances. She, therefore, passed most requests on to members of the nursing staff. As will later be seen from the analysis of staff initiated calls, the clerk utilized the nurses' call system for this purpose.

On the average, patient calls were answered in less than one minute on all but one unit, for both day and night periods of observations as shown in Figure 2, below. This table does not, however, expose the upper extremes that existed on all units. These very long waits were particularly evident on the floor with the highest average wait—medical west. Extreme waiting times were due primarily to the presence of temporarily employed nurses completely unfamiliar with the use of the voice intercommunication system. Long waiting times also existed when shifts were changing in the morning (even though there were large numbers of staff on the unit), and during the night when there were no staff members in the nurses' station. Patient initiated requests were answered faster when the ward clerk was on duty and there was a minimum of activity in the nurses' station.

Fig. 2—Average time lapse in answering patient initiated calls per inpatient unit during day and night observations

	DAY	NIGHT
Surgical West	34.7 seconds	5.3 seconds
Medical West	86.7 seconds	103.3 seconds
WEST AVERAGE	*54.2 seconds*	*54.3 seconds*
Surgical East	46.3 seconds	14.1 seconds
Medical East	41.3 seconds	12.5 seconds
EAST AVERAGE	*44.2 seconds*	*13.3 seconds*
AVERAGE OF ALL INPATIENT UNITS	*49.5 seconds*	*33.8 seconds*

These times refer only to the times the requests were answered on the voice intercommunication system and not to the times when services requested were performed.

PATIENTS CALL FOR SPECIFICS

What were the patient initiated calls about? More than 90 per cent of the calls, both day and night, were requests by patients for a specific article or service (Fig. 3, page 43). Articles or services requested, with minor differences, showed a remarkable consistency between day and night observa-

tions. Approximately one-third of patient requests—a little less during the day and a little more at night—were centered around the bedpan and urinal. These calls included getting the bedpan, emptying it, positioning the patient for it, etc. One-fifth of the day requests and one-fourth of the night requests were for medications, mainly analgesics and sedatives.

The next most frequent request was for a nurse. These were interesting calls in that the patient preferred not to use the system properly by telling the person at the nurses' station exactly what he wanted. He wanted to see a nurse.

Diet requests—separated from requests for water—were greater during the hours when meals were served.

It was noted during the study that patients in four-bed rooms utilized the nurses' call system, as measured by patient initiated requests, 30 per cent less than did patients in single rooms. Several reasons for this can be suggested. For instance, there is more of a chance that a nurse will be in a four-bed room to answer patients' requests without recourse to the call system. Or, it can be hypothesized that the patients in four-bed rooms helped each other and there was, therefore, less need to call the nurse. These questions are important to future hospital design.

Analysis of patient initiated requests contains other valuable information as to the design of the inpatient unit in which the voice intercommunication system is installed. One of the most evident is in the area of patient requests for the bedpan and urinal. This study is an excellent argument for keeping the bedpan at the bedside through individual bedpan technique and toilet hoppers for every room. The desirability of, in effect, turning every room toilet into a "dirty utility room" is clearly demonstrated by this study.

Such innovations will, however, decrease the number of trips saved by the voice intercommunication system. Let us review patient requests purely in the light of nursing trips saved due to the fact that either the nurse knew what the patient wanted before she got to the room, or she could satisfy the patient's request from the nurses' station.

All of the information calls resulted in a trip saved since the nurse or ward clerk could give information without leaving the nurses' station. If the bedpan and urinal were already at the bedside and the toilet hopper in the room, no trip was saved by using the voice intercommunication system in this area. A trip was saved for each of the requests for medication since the nurse, by being forewarned, could bring the medication with her when she went to the patient's room. No trip was saved for the requests for a nurse or for service around the bed. Of patient initiated calls, therefore, 42.6 per cent during the day and 38 per cent during the night resulted in a trip saved. The system, then, did save nurses travel time and effort in answering patient initiated calls, and can, therefore, be considered as performing its nurses call function more efficiently than a system not equipped with a voice intercommunication feature.

Fig. 3—Patient initiated calls—percentage distribution by content

	DAY			NIGHT		
	SPECIFIC ARTICLE OR SERVICE (PERCENTAGE)	INFORMATION (PERCENTAGE)	CALLS	SPECIFIC ARTICLE OR SERVICE (PERCENTAGE)	INFORMATION (PERCENTAGE)	CALLS
All Units	92	8	655	96	4	216
	SPECIFIC ARTICLE OR SERVICE REQUESTED—ALL UNITS					
	PERCENTAGE OF CALLS		600	PERCENTAGE OF CALLS		208
Bedpan	29			34		
Medication	19			26		
Nurse	19			13		
Diet	10			—		
Bed	8			7		
Water	3			8		
Misc.	14			12		

Fig. 4—Trips saved as a percentage of total calls per inpatient visit for day and night observations

	DAY		NIGHT	
	TRIPS SAVED (PERCENTAGE)	CALLS	TRIPS SAVED (PERCENTAGE)	CALLS
Surgical West	53	567	59	32
Medical West	45	303	30	50
Surgical East	52	593	46	106
Medical East	43	604	44	55
All Units	49	2,067	44	243

TRIPS SAVED ON CALLS

A return to the original design (Fig. 4, left) and an analysis of all calls, both staff initiated and patient initiated in the light of trips saved, again results in a pattern with a fair degree of consistency among the units studied. The 49 per cent of calls which resulted in a trip saved during the day and 44 per cent of trips saved during the night hours must mean that a fair percentage of staff initiated calls, as well as patient initiated calls, resulted in a trip saved. Approximately 51 per cent of the staff initiated calls during the day and practically all of the few staff initiated calls during the night saved the initiator a trip. Of all the calls which resulted in a

Fig. 5—Staff initiated calls—percentage distribution—all units

	DAY		NIGHT	
	PERCENTAGE OF CALLS	CALLS	PERCENTAGE OF CALLS	CALLS
FROM WHOM		1,415		27
Ward clerk	75		—	
Charge nurse	18		22	
Others	7		78	
TO WHOM		1,415		27
Nursing staff	70		60	
Patients	12		36	
Doctors	12		4	
Miscellaneous	6		—	
WHAT ABOUT		1,415		27
Page	68		8	
Information	19		85	
Order	13		7	

trip saved during the day observation periods, almost three-quarters were staff initiated calls.

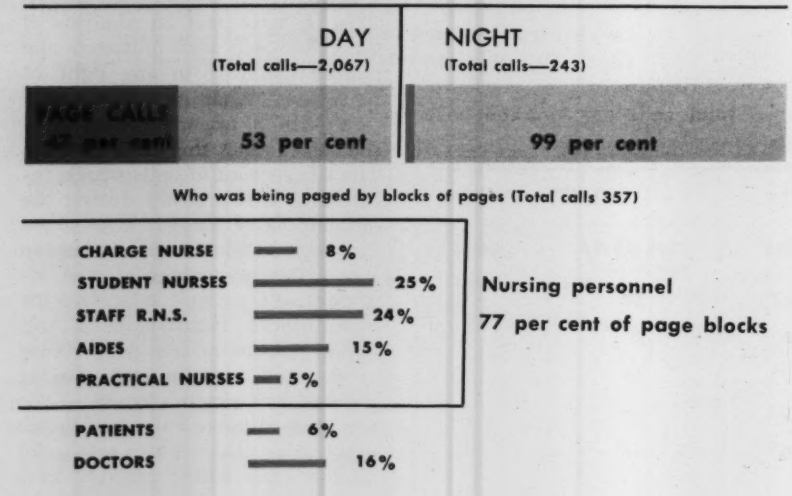
The staff initiated calls were then a critical factor in the saving of nursing time and effort. Fig. 5, above, shows these staff initiated calls broken down into, "from whom," "to whom," and "what about" classifications. The all-unit total is used since there was not a significant difference between units. It was the ward clerk who initiated three-fourths of all staff initiated calls during the day. The charge nurse was a "poor second" during the day and night hours. Other calls came mainly from other nursing personnel who generally initiated calls at night.

To whom were these calls directed? They were primarily directed to members of the nursing staff, while patients were second, and physicians, third.

What was the content of these calls? During the day two-thirds were page calls. A page call in this study is defined as an unsuccessful attempt to contact a specific individual. During the night the main purpose of the staff initiated calls was to communicate information. In other words, at night a member of the nursing staff, other than a charge nurse, usually passed information to another member of the nursing staff. During the day the most usual call was the ward clerk's paging a member of the nursing staff.

The page as defined (an unsuccessful attempt to locate a specific individual) represents an inefficient use of the voice intercommunication system. It was also a use that was bothersome to patients. If pages are examined in relation to total calls, rather than staff initiated calls, (Fig. 6, below) almost one-half of the total system activity during the day was devoted to pages. One characteristic of these pages is that they were in strings of multiple calls. If the seeking individual did not locate the desired individual at one location, he tried another room or used the corridor station in a little louder voice. If all the strings of duplicate calls are eliminated and page "blocks" are thus isolated, a clearer picture of who was being sought emerges. Figure 6 shows that 357 individuals were being sought or about 2.5 calls per individual paged. Generally, nursing personnel were being paged (77 per cent of the page block). Slightly more than one-sixth of the individuals sought were physicians. Only 6 per cent of the individuals sought were patients. Why were staff members paged? Because their exact location was not known, in spite of the "full view" from the nurses' station.

Fig. 6—Page calls as a percentage of total calls—all units

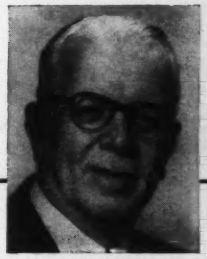


BUILT-IN LOCATING DEVICE

If the "nurses' call" system was being used as a staff intercommunication system—and this has been demonstrated—and if such a use was desirable—the study showed time and effort of the nursing staff were saved by staff calls—then a method of minimizing the undesirable and inefficient paging feature should be considered. Some type of locating device should be built into the system to be used primarily by nursing personnel. This locating device could indicate to the ward clerk, or to whoever was manning the central station, the fact that a nurse or aide was in a certain room.

This locating device could be a light activated by the nurse or aide when she enters the patient's room. A special color bulb would then light up above the patient's door and at the room location on the master station. This feature certainly would cut down the number of pages and increase the efficiency of the system since the

(Continued on page 92)



your president reports

I HAD HOPED that I could avoid putting myself into a position of discussing hospital costs. For as many years as my memory serves me, hospital costs have been increasing and hospital people have been explaining. During the Mid-year conference of 1948 the theme of "telling the public about hospital costs" occupied a prominent spot on the program and discussion. The late Graham Davis in his past presidential year put it in this fashion:

"The hospital is not out to make a profit, but it is supposed to give the consumer the greatest possible return for his money. To convince him he is getting full value for his health dollar, an effective public relations program is necessary. Call it advertising if you like. Otherwise, the hospital gets lost in the scramble for the consumer's dollar in the age of the atom and the singing commercial."

Then President Joseph Norby about the same time said almost the same thing in another way:

"The American public requires an effective health service, one that is readily available, one that is provided in a way and at a price that is both satisfactory and acceptable to the people, one that is available on the basis of need without regard to the ability of the individual to pay. There is still evidence that the American people wish to purchase this service on the same basis that they now provide themselves with clothing, food, and other personal necessities. Industry has demonstrated its willingness to assist and to bear a large portion of the cost. The professions continue to contribute services, time, and study. Government has evidenced a willingness to cooperate. Those of us charged with the administration of this program now must assume more than ever before a full measure of the responsibility for our great public trust. We cannot transfer this responsibility to others, nor can we surrender our present enviable position of freedom of action. But with eyes to the future, courage in our hearts and strength in our determination, we must continue to go forward, unafraid."

LAST DECEMBER I had the privilege of addressing the American Insurance Association. Here, again, I renewed the statements that have been made by Ray Brown, George Bugbee, and Dr. Crosby about hospital costs and placed my own interpretation on them in somewhat the following way: The duty of hospital administration is to create the right environment for the good practice of institutional medicine and to surround the patient and the physician with all the tools of science and medicine that will eventuate recovery—let the cost be what it may. Not the best hospital care at the price the patient can afford to pay but the best hospital care regardless of cost.

This program has led the hospitals into a situation that has aroused the interest of many. The public is aware that hospital costs have increased beyond the average index of most other commodities. Critical articles appear in the press and the question of hospital efficiency is then raised. We in hospital administration are stunned at these questions—we ask ourselves, "Should we retreat from our present standards and provide care of lesser quality?" A good physician would not wish to send a patient to a hospital without all the necessities that are essential to recovery. Certainly, you would not wish to send a member of your family to a hospital or go to one yourself unless you were assured that the tools of recovery which I speak about are present. The answer must come from some other party than those engaged in medicine and hospital care. Surely, there is to be no reduction in standards to be suggested by practitioners in the field.

We have our own ideas of the economy of hospital operations and feel that the care of the ill on the whole is done efficiently and, best of all, with results that will justify the cost. We in hospital careers feel the impact of revolutionary medical and social advances, and we are doing our best not only to adapt to them but also to advance hospital care as rapidly as possible. We think that there is much misunderstanding of the problem—confusion existing between the quoted high cost per hospital day and the real cost of per patient stay—which is the price paid for in more than 96 per cent of hospital admissions for the hospital contribution to recovery from illness.

The principal landmark and the greatest feeling of satisfaction that comes from my more than 35 years in the administration of a hospital is the reduction in patient mortality. In this period I have witnessed the death rate of our institution's patients, who have the advantages of the advances in medical science and practice, reduced from more than 10 per cent of admissions to approximately 3 per cent with no appreciable change in the character of patient admitted. Here I ask, "Is the price too high?"

Ray Amberg

Ray Amberg, president
American Hospital Association

ASSOCIATION SECTION

The following actions were taken by the Board of Trustees of the American Hospital Association at its meetings in Chicago on Nov. 20-21, 1958. Further actions of the Board will be reported in subsequent issues of this Journal.

JEHOVAH'S WITNESSES AND BLOOD TRANSFUSIONS

VOTED: To approve the statement titled, Jehovah's Witnesses and Blood Transfusions, and the form for Refusal to Permit Blood Transfusion, as revised.

JEHOVAH'S WITNESSES AND BLOOD TRANSFUSIONS*

Approved by Board of Trustees Nov. 21, 1958

It is suggested that the following points receive consideration by hospitals in the case of persons whose religious faith prohibits the transfusion of blood:

1. If the patient is an adult, a written refusal is recommended to absolve the hospital, the physician or physicians, and all other assisting personnel from liability, if any, for the failure to administer blood.

2. If the patient is legally too young to make his own decisions, the written refusal of the parents, if available, should be secured. (In certain instances courts have intervened to authorize transfusions to minors in spite of the objections of their parents.)

3. In emergencies, and where release of the parents of minors is not obtainable, it would be expected that blood would be administered when medically indicated unless clear and convincing evidence is at hand that the patient, if conscious, or the parent, if present, would refuse transfusion.

4. Jehovah's Witnesses consider blood derivatives objectionable, but do not object to the use of blood substitutes.

5. Representatives of Jehovah's Witnesses state, "that a physician who is one of Jehovah's Witnesses may, according to his belief in the Bible, administer blood, if he can conscientiously do so, when required for the patient who has no objections or who does not indicate that he is one of Jehovah's Witnesses, when ordinary usage and customary professional practice require it. If he desires to withdraw because of conscientious objections to blood transfusion based on religious scruples, and he may professionally do so without serious hazard to the patient, he may turn the case over to another physician."

6. In view of the foregoing paragraph it is desirable that provision be made within the hospital for the administration of blood to patients who do not object to its use, in the event that medical staff members are unwilling to administer blood because of their religious beliefs.

*This statement was prepared by the Council on Professional Practice's Committee on Blood Transfusions—Jehovah's Witnesses, consisting of: Lloyd H. Gaston, M.D., chairman; Kenneth B. Babcock, M.D.; Loyal Davis, M.D.; Emanuel Hayt; Leonard Larson, M.D.; Alexander S. Wiener, M.D.; in consultation with Hayden C. Covington; E. G. Gillmore, M.D.; and Edwin J. Holman.

_____
(Name of Hospital)

REFUSAL TO PERMIT BLOOD TRANSFUSION

Date_____ Hour_____ .m.

I request that no blood or blood derivatives be administered to_____ _____ during this hospitalization. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

Signature of patient_____
Signature of patient's husband or wife_____
When patient is a minor or incompetent to give consent:
Signature of person authorized to consent for patient_____
Relationship to patient_____

Witness:_____

OFFICIAL MEETINGS

Feb. 2	Coordinating Council	Chicago
Feb. 3	Board of Trustees	Chicago
Feb. 4-5	Committee on Nominations	Chicago
Feb. 12-13	Committee on Accounting and Business Practices	Chicago
Feb. 19-20	Committee on Personnel Administration	Chicago
Feb. 23	Scholarship Selection Committee	Chicago
Feb. 27	Professional Activities Study	Chicago

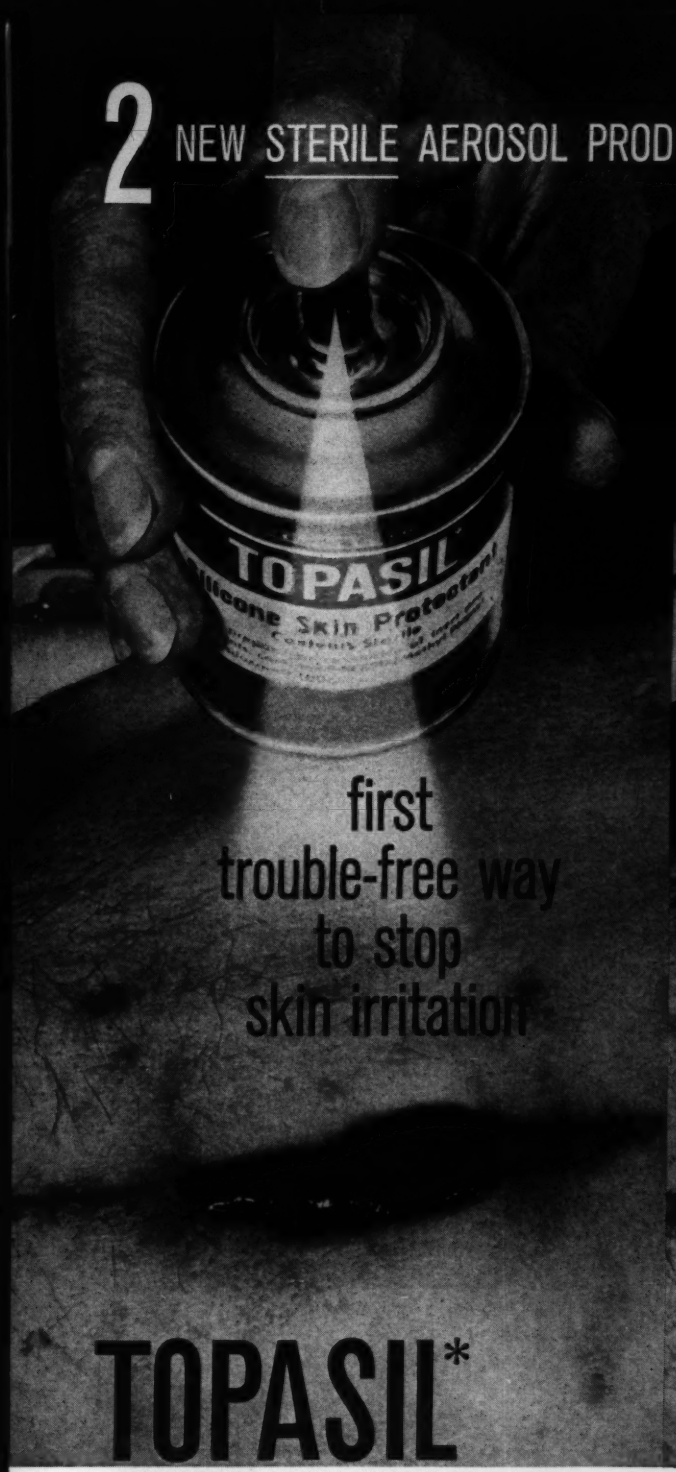
AUDIT OF PHYSICIANS' FINANCIAL RECORDS

VOTED: To inform the American Medical Association that the American Hospital Association considers the problem of the audit of physicians' financial records primarily a matter concerning professional ethics and not properly a subject for policy pronouncement by the American Hospital Association.

HOSPITAL ORIENTATION OF PHYSICIANS

VOTED: To authorize preparation and/or sponsorship of one or more training films to help orient medical students and physicians to hospitals.

2 NEW STERILE AEROSOL PRODUCTS FOR BETTER PATIENT CARE:



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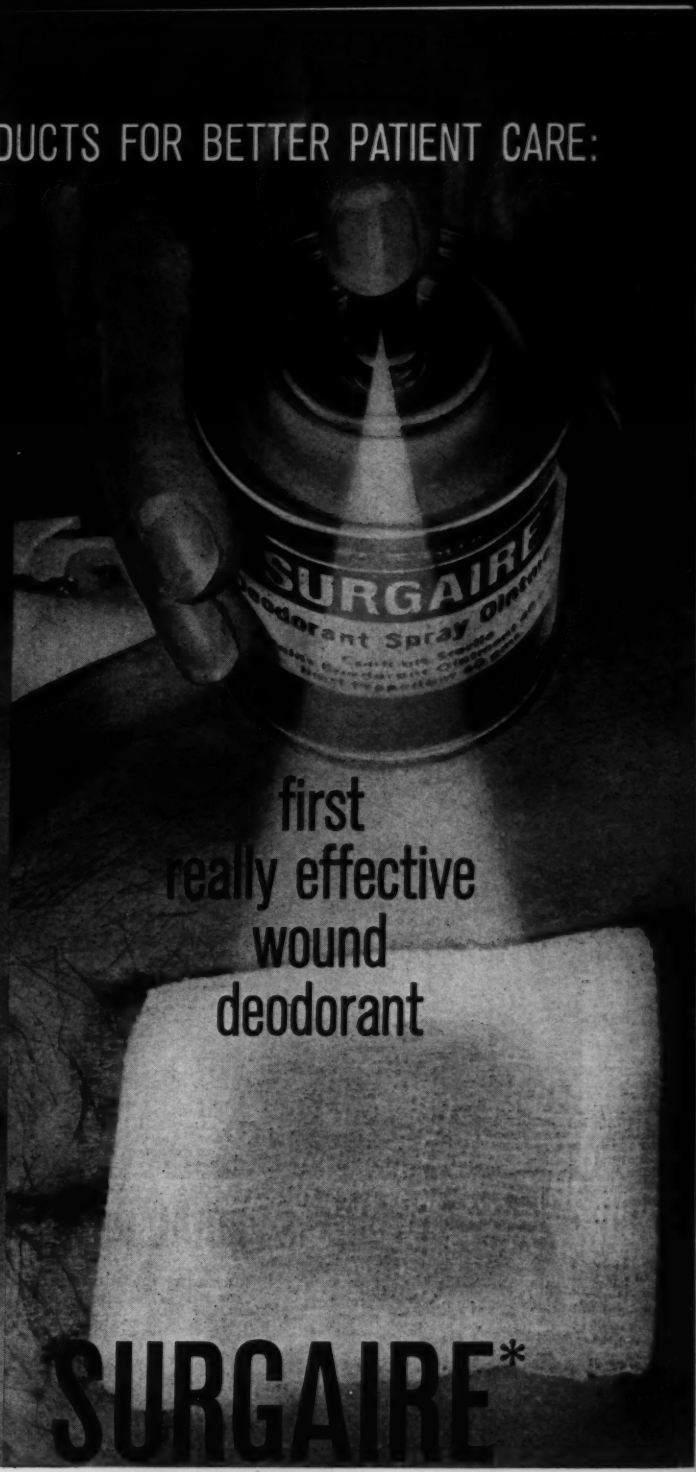

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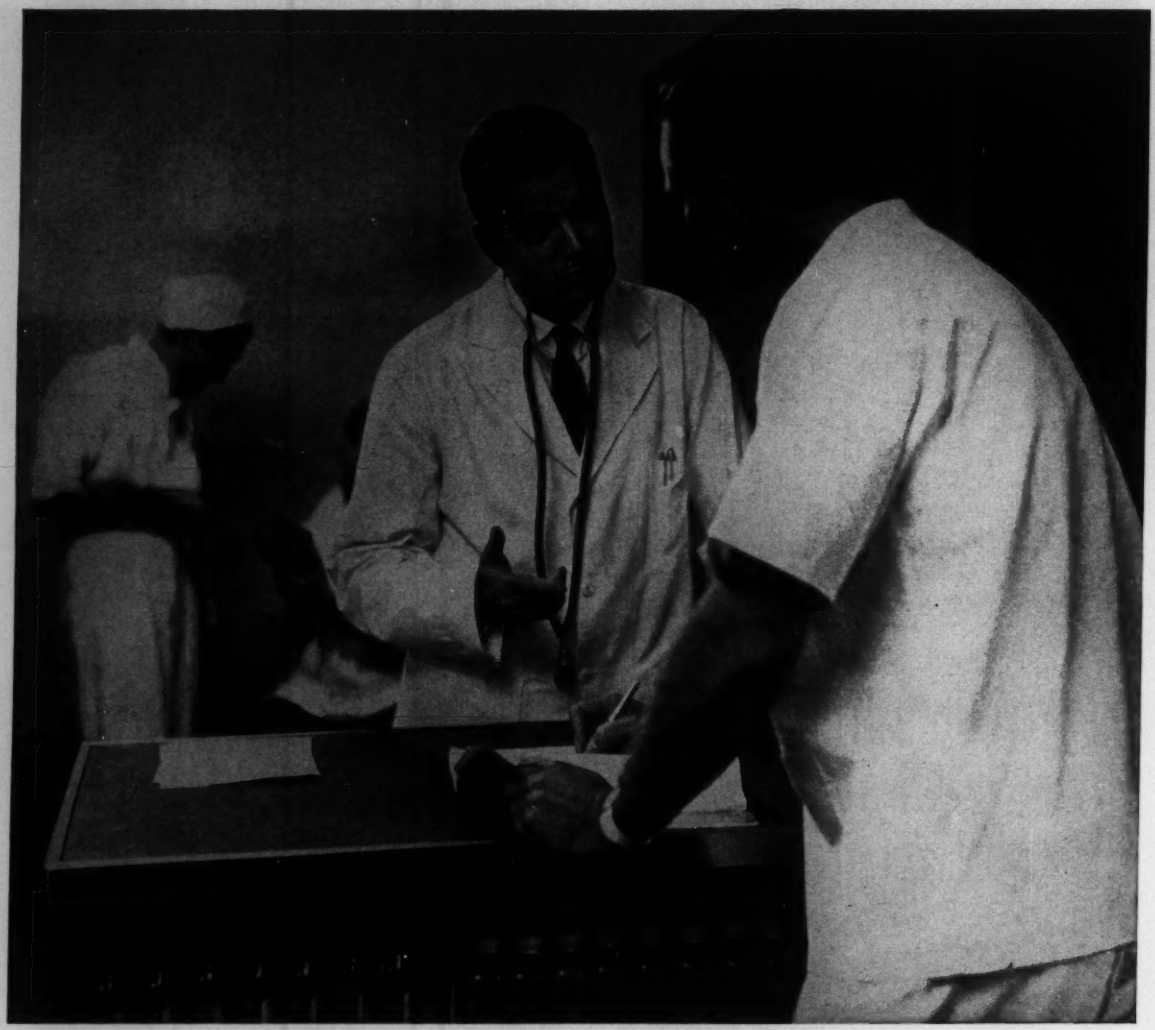

"YES...I HAVE SPECIAL REASONS FOR SPECIFYING BUFFERIN"

There are a lot of reasons why so many physicians specify Bufferin. For instance, it's *better tolerated* than plain aspirin—many times better tolerated according to one recent study[1] of 236 patients. Therefore, it's the choice when high-dosage or long-term salicylate therapy is indicated. And Bufferin *contains no sodium* —so it's ideal for effective pain relief when the patient's on a low-salt or salt-free diet.

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1. Sher, D. B.: Aspirin and APC Irritation of the Stomach, Scientific Exhibit, World Congress of Gastroenterology; Washington, D.C., May, 1958.

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ALTHOUGH motivation is often difficult to develop in long-term patients, the staff of the chronic disease division, Jewish Hospital of St. Louis, has found that once patients become interested in occupational therapy projects, they usually work on them eagerly and with pleasure.

ORGANIZING AND OPERATING

a chronic disease unit in a general hospital

(Continued from page 30)

patient who is accepted is ultimately admitted. At times other plans are made by the family or the application is withdrawn.

● **Discharge procedures**—Patients are discharged when their condition has improved to a point where hospital care is no longer required. Discharge plans are handled by the social worker who is familiar with the home situation. She will help the family to work out a plan for further care. No patient is asked to leave until such a plan is carefully formulated. The medical director participates in planning by direct consultation with the family or by conferring with the social worker. The medical director does not have authority to discharge a private patient. He may, however, contact the attending physician and suggest to him that his patient no longer needs hospital care. This indirect control over the use of the chronic disease division by private patients has proved workable.

In the case of discharge, (Table 7, right) 7 patients (6 per cent) were returned to the acute divisions for more intensive treatment. Nine (7 per cent) were discharged to nursing homes or other institutions because they needed less intensive care. Seven (6 per cent) more were placed on the home care program. Forty-five patients (35 per cent) were discharged to their own homes in improved condition. The balance (46 per cent) were discharged by death.

The average length of stay for all patients admitted was 168.9 days during 1957. This figure was distorted by the several custodial and nursing home type patients on the program (Table 8, right).

TABLE 7—Disposition of patients discharged from chronic disease division during a 12-month period

DISCHARGED TO:	NUMBER
Jewish Hospital, acute, private	1
Jewish Hospital, acute, service	6
Home	45
Home care	7
Nursing home	7
Other institutions	2
Dead	57
	125

TABLE 8—Length of stay of patients on chronic disease division during a 12-month period

FUNCTIONAL CATEGORY	LENGTH OF STAY (ON DISCHARGES)
Chronic	131.9 days
Nursing home	338.1 days
Custodial	511.2 days
Average length of stay	168.9 days

The length of stay for the treatable chronically ill patients was 131.9 days. ■

REFERENCES

References for Part I and Part II will appear in the next issue of this Journal.

AT ASHP-AAAS SESSIONS—

Hospital pharmacists hear of future

The hospital pharmacist of the future will be more highly educated, more versatile in hospital management, and much more of an executive than a technician. Furthermore, approximately one-fourth of future hospital pharmacists will be women.

These were among predictions made by four panelists representing an educator, a physician, an administrator, and a pharmacist at a session on hospital pharmacy during the 1958 annual meeting of the American Association for the Advancement of Science December 26-31 in Washington, D.C. The American Society of Hospital Pharmacists, a sponsor of the program, is an affiliate of AAAS.

Dean Charles W. Bliven of the School of Pharmacy, George Washington University, said specialized hospital pharmacy education must be added to the curriculums of four- and five-year programs in pharmacy if they are to keep pace with the needs of hospitals

"Internship training programs will continue to have an important place in hospital pharmacy education," he said, "but they cannot substitute for a well organized graduate program." *(For a development in this area, see box, this page.)*

For pharmacy education programs of the future, Dean Bliven stressed the importance of histology, anatomy, and knowledge of investigational and radioactive drugs.

Discussing pharmacy manpower needs of the future, Dean Bliven said "womanpower" will likely play an increasing role in filling these needs. In schools of pharmacy, women will soon constitute 15 per cent of the graduates, he said. Dean Bliven expects this proportion to mount to 25 per cent.

MORE PRESCRIPTIONS

Kenneth R. Nelson, M.D., chief of the Division of Hospitals, U.S. Public Health Service, speaking from the physician's viewpoint, said hospital pharmacies of the future will handle a greatly increased volume of prescriptions, owing to the growing number of hospitals that provide rental space for practicing physicians.

Future hospital pharmacies will be larger, Dr. Nelson said. Between 25 and 30 per cent of total drug dollar volume is now handled in hospitals, he said, and this percentage is increasing.

Dr. Nelson said the pharmacist of the future will serve as a drug therapy consultant to staff physicians rather than perform routine technical duties, which will be delegated. Over-all drug charge systems will be commonplace, he said.

A TRUE PROFESSIONAL

"The hospital pharmacist will be a true professional, entirely distinct from the retail pharmacist," said Charles U. Letourneau, M.D., director of the Northwestern University Program in Hospital Administration, speaking as a hospital administrator.

He said the specialized knowledge needed by the pharmacist for carrying out his duties in the hospital will necessitate educational patterns different from those of the retail pharmacist.

Joseph A. Oddis, staff representative, Council on Professional Practice, American Hospital Association, predicted that the hospital pharmacist will participate more actively in clinical meetings of the medical staff and will work closely with the attending physician in recommending drug therapy for a given diagnosis, Mr. Oddis said.

The future pharmacist will have to take the responsibility for providing 24-hour drug service, he said, but he will be doing very little compounding and manufacturing. Only nonavailable products, unusual dosage forms, and special investigational drugs will be prepared, the rest being left to manufacturers, Mr. Oddis concluded.

INJECTION COSTS NARROW

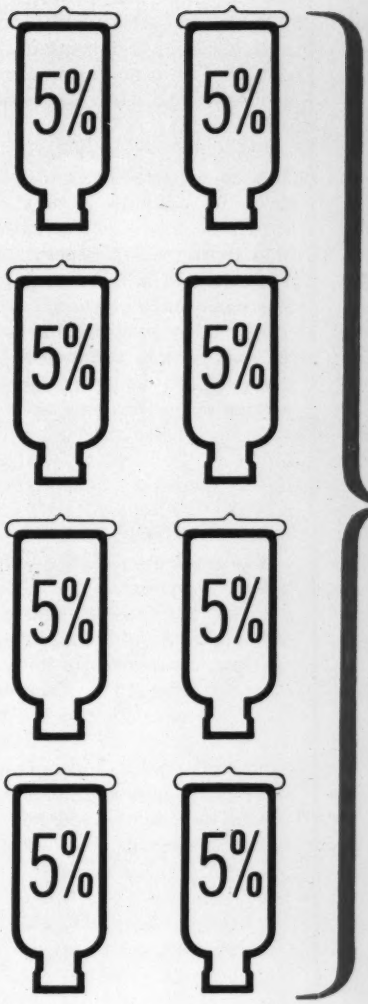
Although the cost of administering injectables by means of a closed system is still higher than that with the conventional method, the differential is steadily narrowing, reported Kenneth R. Nelson Jr., Office of the Surgeon General, U.S. Public Health Service, in an earlier hospital pharmacy session.

Mr. Nelson compared figures developed in a recently completed

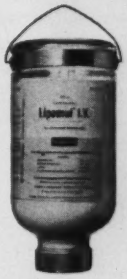
COLUMBIA TO OFFER GRADUATE HOSPITAL PHARMACY PROGRAM

A graduate program of education in hospital pharmacy will be in the Columbia University College of Pharmacy beginning with the fall of 1959, according to an announcement January 6 by Dean E. E. Leuallen. Several teaching hospitals in greater New York have indicated an interest in cooperating in the program, which involves the completion of 30 graduate credits in the college and the full internship program of the American Society of Hospital Pharmacists in an accredited hospital pharmacy.

In a statement concerning the new program, Dean Leuallen said, "Never before has the hospital pharmacist faced so many challenging opportunities to demonstrate his scientific, professional and administrative capabilities. The graduate of this new program, schooled in biochemistry, modes of drug action and toxicology, knowing the techniques of formulation and stabilization, aware of the significance of quality control, and experienced in administrative functions, will add new dimensions to the service offered in many hospitals."



NEW **LIPOMUL*** **I.V.** PROVIDES



8 TIMES THE CALORIES OF 5% DEXTROSE

- high energy fat for intravenous feeding.
- the first formulation to assure adequate caloric supply.
- prevents cachexia and promotes recovery.
- spares body protein.
- provides high caloric intake in low fluid volume, thus eliminating the necessity of prolonged administration and overhydration—1 liter of Lipomul I.V. supplies 1,600 calories, while 1 liter of 5% dextrose or 5% protein hydrolysate supplies only 200 calories.
- completely metabolized.
- makes possible higher concentrations of fat without irritation of venous endothelium.
- essentially devoid of electrolytes and nitrogen—can be lifesaving when renal function is markedly impaired.
- has minimal side effects: incidence of reactions less than 5% in 4,000 infusions.

See package literature for dosage, administration, and precautions.

Supplied: Lipomul I.V. is a sterile, nonpyrogenic, oil-in-water emulsion supplied in 500 cc. bottles for intravenous use. Each bottle contains cottonseed oil 75 Gm., glucose 20 Gm., and soybean phosphatide 6.0 Gm. Included in each package is an intravenous administration unit which must be used in all Lipomul I.V. infusions. The package must be stored in a refrigerator and protected from freezing. The unit is not for multiple-dose use, and any unused portion should be discarded.

*TRADEMARK, REG. U. S. PAT. OFF.

Upjohn *The Upjohn Company, Kalamazoo, Michigan*

study with parallel figures in a study made four years ago. The cost of giving a closed system injection now ranges from 2.1 cents to 6.1 cents above the cost of a conventional injection, he said. As pharmaceutical manufacturers gain more experience in producing these items and as the range of available medications is widened, he said, costs can be expected to decrease further in relation to costs of the conventional method.

Costs of both systems probably will continue to rise, however, Mr. Nelson said. Rising salary levels may bring the cost of the two systems to a "crossover point" where both will be equal. Meanwhile, the closed system offers advantages that "cannot be given a price tag", he said.

RESPONSIBILITIES MULTIPLY

Administrative responsibilities of the hospital pharmacist have multiplied tremendously in recent years, Dr. Letourneau declared in a talk on the pharmacist's role in administration.

"Unless the pharmacist is well grounded in management principles he is practically no help to the administrator," he said.

Daniel F. Moravec, director of pharmacy service at Lincoln (Nebr.) General Hospital, in a paper discussing the research potential in hospitals, stated that students in this field must be made to realize that hospital pharmacy research is scientifically alive. In the absence of Mr. Moravec, the paper was read by Dr. Letourneau.

To demonstrate the vitality of hospital pharmacy research, Mr. Moravec described a number of specific pharmaceutical problems involving patients in which creative research was used to find a solution. He said a cooperative working team composed of the physician and pharmacist can be the key to solving such problems.

PHARMACY BOARD SURVEY

Results of a survey of relationships between state boards of pharmacy and hospital pharmacies were outlined by Fred T. Mahaffey, assistant to the secretary of the National Association of Boards of Pharmacy. Forty-five out of 49 pharmacy boards queried replied. Some of the findings:

- In 31 of the states from which questionnaires were returned, boards of pharmacy have sole jurisdiction over hospital pharmacies and drug rooms. Boards of health have jurisdiction in another 6, and the authority is shared with another health group in 5 states. In 3 states there is no vested authority over hospital pharmacies.
- 29 pharmacy boards are given the power to license hospital pharmacies, and 17 boards license nursing home pharmacies.
- 40 states require the services of a pharmacist to be available at all times; these states also define certain minimum equipment standards for hospital pharmacies.
- Boards of pharmacy have the power to inspect hospital pharmacies in 37 states, and in 18 states, this inspection includes floor nursing stations and general procedures for handling dangerous drugs and narcotics.
- 12 states make no stipulation as to how large a hospital can be without having a pharmacy, but 32 make such a stipulation.

Mr. Mahaffey said the survey showed that most states require that medications given in nursing homes be obtained from regular licensed outlets, and that medications be controlled by the administrator.

CHRONIC HOSPITAL PHARMACY

Evolution of the pharmacy service at Keswick, an "intermediate long-term facility" in Baltimore, was traced by Virgil A. Halbert, executive director.

Keswick is a facility designed for the needs of chronically ill patients for whom the nursing home is inadequate and the acute general hospital inappropriate, Mr. Halbert said. The institution provides a home and community life in which chronic hospital care is an integral part of daily living, he said.

In recent years, as the hospital developed its facilities to meet the needs of patients it now serves, Mr. Halbert said, it was found that the existing nurse-supervisor drug room system was becoming more and more inadequate.

In 1956 a general pharmaceutical survey was conducted for the purpose of bringing pharmacy service up to the same level as the diagnostic and therapeutic programs and to establish the practice of pharmacy as a professional service conducted by properly qualified personnel.

The associate director of nursing is now responsible for drug dispensing, purchasing, and control, Mr. Halbert said, and there has been no compounding done at the hospital since 1956. "Maintenance pharmaceuticals" form the bulk of drugs stocked; use of narcotics is extremely small. Patients requiring more complex parenteral medication or extended oxygen therapy are transferred to a short-term general hospital, he said.

The hospital currently is attempting to establish a liaison with a general hospital that would provide both personal services of professional pharmacists as well as pharmaceuticals, paid for on a monthly basis. The general hospital would be expected to assist in the establishment of needed control systems and to furnish the pharmacy representative to a pharmacy and therapeutics committee, Mr. Halbert said. ■

Formulary system topic of two talks

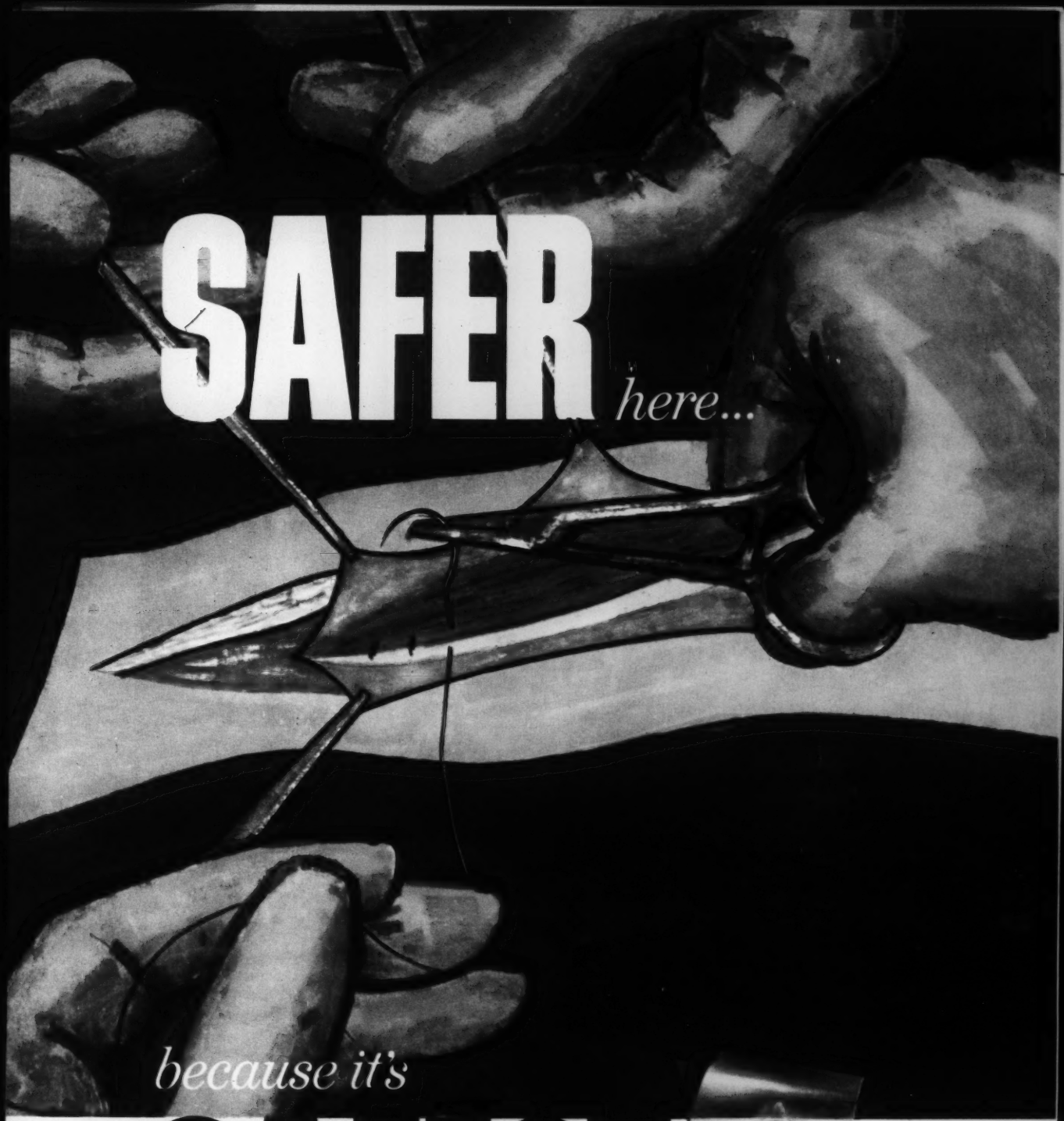
The hospital formulary system was the subject of two talks given during the sessions on hospital pharmacy at the AAAS annual meeting.

The greatly increased responsibility for purchasing that falls to the pharmacist in a hospital using the formulary system was the topic of a paper prepared by Herbert S. Carlin and Herbert L. Flack.

Mr. Carlin is chief of the education and research division, pharmacy service, and Mr. Flack is director of pharmacy service, Jefferson Medical College Hospital, Philadelphia.

Mr. Carlin, who read the paper, pointed out that the formulary system, through the carte blanche permission granted by the medical staff to dispense under the generic name any brand of identical drug or chemical agent, charges the pharmacist with the responsibility

(Continued on page 92)



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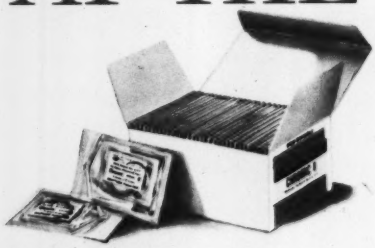

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American Hospital Association PURCHASING GUIDE

This purchasing guide is one of a group developed or brought up to date during the last year by and for members of the American Hospital Association Personal Membership Department for Hospital Purchasing Agents. The guides were presented for comment and criticism of Department members in the *Hospital Purchasing Agents' Newsletter* and are being printed in final form in this Journal in order to make them more widely available in the hospital purchasing field. Pages on which the guides appear are perforated so that they can be easily removed and filed for future reference.

ITEM: SHEETS, BED, COTTON (Bleached)

FED. CLASS NO. 7210, Household Furnishings

FED. GROUP NO. 72, Household and Commercial Furnishings

KEY POINTS:

1. Sizes should be uniform throughout the hospital.

   Standard (torn) sizes: 63x99, 63x108, 72x99, 72x108

   Most common size: 72x108

2. Fiber: 100 per cent cotton.

3. Types:

   128 medium white muslin (carded yarn)

   140 heavy weight muslin (carded yarn)

   180 "utility" percale (combed or carded yarn)

   200 "luxury" percale (combed yarn)

   Most common type: 140

The type of number is the same as the minimum number of threads per square inch. This is obtained by adding the number of threads per inch in the warp and filling. The number of threads in the warp should usually exceed those in the filling by approximately 10 per cent. The warp is usually the lengthwise threads. Thread counts are determined from unbleached cloth and will usually be slightly higher in bleached sheeting.

4. PHYSICAL REQUIREMENTS:

	Type 128	Type 140	Type 180	Type 200
Breaking strength (grab method) of warp & filling (min. lbs.)—	55	70	60	60
Weight (min. oz. per sq. yd.)—	4.0	4.6	3.6	3.6
Maximum sizing added—	6%	4%	2%	1%

5. SHRINKAGE — A maximum of 7 per cent shrinkage is a commonly accepted standard even though this figure is not part of an existing standard.

6. WEAVE — The weave should be plain and firm throughout without loose or tight areas.

7. HEMS — A 1-inch hem on either end is called for in the federal specification; however, many hospitals find that a 2-inch hem on either end provides a neater looking bed.

8. STITCHING — A minimum of 14 stitches per inch.

9. Sheets should be clean, have even selvages, and be free of defects.

10. COLORS — All colors, including identifying marks, should be fast, with no running or fading when washed in standard washing formulas using active chlorine.

11. QUALITY — Sheets should be known commercially as "firsts" unless "seconds" are specified on purchase order. Defects which classify sheets as seconds should be known by the purchaser and should not affect the appearance or serviceability of the sheet.

TESTS:

1. SHRINKAGE — Measure sheet before and after first laundering to determine amount of shrinkage. Several sheets for each order should be tested and an average determined for the lot.

2. SIZING — Weighing the dry sheet before and after laundering will give a rough measure of the amount of sizing present. Visual and hand inspection of unwashed and washed sheets should also be made. A heavily sized sheet will lose much of its crispness and body during washing.

3. PULLING — Good quality sheets will usually fold square after laundering and ironing. Note hems and selvage for pulls and tucks after washing.

4. DURABILITY — Sample sheets may be subjected to normal use for comparison with current product or other samples. An accurate count of washings is necessary for best comparison.

5. OTHER TESTS — Specific tests for evaluating the various technical aspects of the sheet, such as crocking, hem strength, color fastness, warp and filling strength, and finish, are contained in Part V of *American Standard Minimum Performance for Institutional Textiles* and Commercial Standard CS 59, *Textiles, Testing and Reporting.*

REMARKS:

Purchase orders should contain the following notation: "The sheets listed on this purchase order should meet or exceed American Standard L 4.1."

REFERENCES:

When ordering the above items, refer to the following for further details:

1. American Standard L-4, *Specifications for Bleached Cotton Bed Sheets and Pillowcases.* American Standards Association, 70 East 45th Street, New York 17, N.Y. $6.25.

2. U.S. Department of Commerce Simplified Practice Recommendation R-74, *Hospital and Institutional Cotton Textiles.* U.S. Government Printing Office, Washington 25, D.C.

3. *Hotel Textile Purchasing Guide.* American Hotel Association, 221 West 57th Street, New York 17, N.Y. $7.50.

4. Federal Specification DDD-S-281c (1) *Sheet, Bed; Cotton (Bleached).* U. S. Government Printing Office. 5 cents.

5. Federal Standard No. 59, *Sheet, Bed; Cotton (Bleached).* U.S. Government Printing Office. 5 cents.

6. Federal Specification CCC-T-191b (4) (Part 1), *Textile Tests.*

The hyper-anxious hypertensive needs greater central control **Serpasil®**

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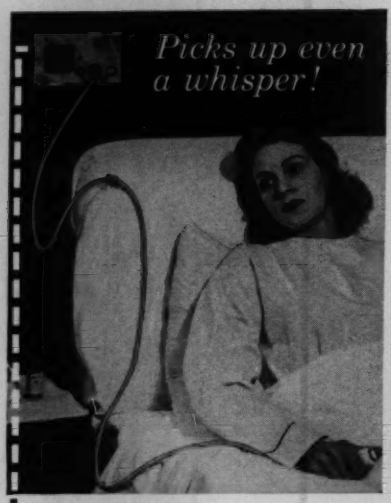
Hypertensive patients whose emotional disturbances cannot be controlled by agents which have no autonomic action need Serpasil: it acts on the central autonomic mechanisms which control reactions to stress. Thus, Serpasil not only lowers blood pressure, but eases the anxiety and agitation that contribute to your patient's hypertension.

DOSAGE: In the average patient not receiving other antihypertensive agents, the average initial dosage is two 0.25-mg. tablets daily, with a range of 0.1 to 1 mg. Later the Serpasil dosage should be reduced to 0.25 mg. or less daily for maintenance. SUPPLIED: *Tablets*, 0.1 mg., 0.25 mg., 1 mg., 2 mg. and 4 mg.

2/2638 MB

CIBA SUMMIT N. J.



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Insist upon Auth VOKALCALL for your hospital. Visual (only) nurses' call systems also available.

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Business_____
Address_____
City_____ State_____

equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

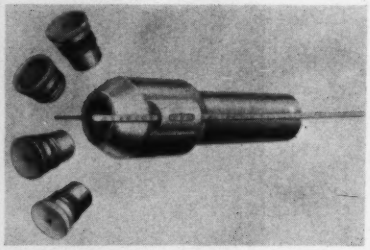
Floor cleaning equipment (3D-1)

Manufacturer's description: Designed for hospitals, where quiet is essential, this new cleaning equipment is

ideal for cleaning occupied rooms. The new line includes oval mop buckets, silent mop wringers, and a soundproofed mopping truck. Soundproofing is achieved through the use of heavy-duty rubber insulators at all contact points, friction bails on bucket handles, and rubber casters on the truck chassis. Buckets are available in 16 qt. through 50 qt. capacity. *White Mop Wringer Co., Dept. H3, Fultonville, N.Y.*

Scintillation counter (3D-2)

Manufacturer's description: Transistorized scintillation counter is primarily used in thyroid evaluations, circulation studies, kidney function tests and localization of metastatic masses and adenomas. It is designed for use with any make of scaler or count ratemeter. To



▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

_____ Floor cleaning equipment (3D-1)
_____ Scintillation counter (3D-2)
_____ Silent floor machine (3D-3)
_____ 30-quart mixer (3D-4)
_____ Mobile x-ray unit (3D-5)
_____ Elastic bandages (3D-6)
_____ Parts and tools cabinet (3D-7)
_____ Slide sorter (3D-8)
_____ Carton sizer (3D-9)
_____ Cardiac stimulator (3D-10)
_____ Automatic dishwasher conveyor (3D-11)
_____ Diagnostic x-ray unit (3D-12)

PRODUCT LITERATURE

_____ Automatic rotary presses (3DL-1)
_____ Caster and wheel manual (3DL-2)
_____ Revolving tray ovens (3DL-3)
_____ Color coded light fixtures (3DL-4)
_____ Folding wheel chairs (3DL-5)
_____ Fire protection (3-DL6)
_____ Gelatine recipe cards (3DL-7)
_____ Inhalation therapy (3DL-8)
_____ Time and cost record book (3DL-9)
_____ Ice cube machines (3DL-10)

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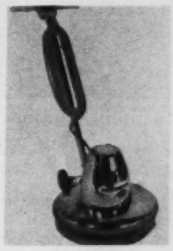
permit shielding for any type of test, the counter includes five screw-in collimators that are interchangeable in less than 10 seconds. Among these is the exclusive "A" filter with 1/16-in. lead shield to replace the usual large bulky plate type filters. A removable sliding variable spacer is calibrated in centimeters. The unit carries a two-year warranty. *Nuclear Measurements Corp., Dept. H3, 2460 N. Arlington Ave., Indianapolis 18, Ind.*

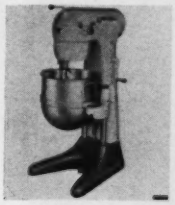
Silent floor machine (3D-3)

Manufacturer's description: This 20-inch silent floor machine has a new type gear reducer, separated from the motor for quieter operation and simpler repair. The 1 h.p. motor rests directly over the brush with the weight assuring balance, uniform coverage and effective use of power. Runaways are prevented by the safety switch which instantly stops the machine once the grip on the handle is released. The machine is available with more interchangeable accessories than any other previous model. *Huntington Laboratories, Inc., Dept. H1, Huntington, Ind.*



30-quart mixer (3D-4)

Manufacturer's description: New 30-qt. mixer is built for a wide range of mixing, beating or whipping applications. Powered by a ½-h.p. motor with direct drive gear, the mixer features a three-speed transmission with all components sealed securely for sanitary long-life performance. The base, column and transmission housing are of close-grained cast iron for assured durability. The 30-qt. bowl is heavily tinned steel with sanitary open style lip and smooth contours for easy cleaning. *Toledo Scale, Division of Toledo Scale Corp., Dept. H2, Toledo 12, Ohio.*



Mobile x-ray unit (3D-5)

Manufacturer's description: New 200-mil-

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PRESCO's identification system is especially designed to meet the requirements of the A.H.A. and American Academy of Pediatrics.

The fastest, easiest method for positive patient identification! Made of soft, pliable, non-toxic plastic, in blue or pink. Snaps on with slight pressure. No tools needed! Conforms to baby's wrist or ankle.

PRESCO's "Multiple Ceremony" system provides identification for mother and baby. PRESCO's "Adult System" also available for use in surgical cases, blood transfusions, etc. 5 separate systems for every hospital need.

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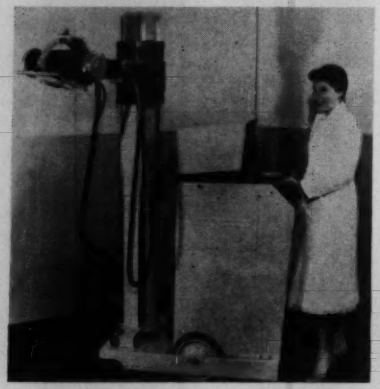
liampere x-ray unit can be moved from room to room to make radiographs without moving the patient from bed. Two 4-inch casters at



the forward end and two 10-inch diameter wheels at the unit's center of gravity ensure easy maneuverability. A 3-inch caster at the rear enables the unit to be tilted slightly to clear obstacles and enter elevators. To provide maximum x-ray picture quality, a milliampere-seconds timing device and an exposure assurance circuit are used. *Westinghouse X-Ray Department, Dept. H3, P.O. Box 416, Baltimore 3, Md.*

Elastic bandages (3D-6)

Manufacturer's description: These lightweight, porous dressings provide a wide range of controllable tension for pressure or support. The bandage has a high degree of elasticity and is physiologically inert. The material of the bandage prevents slipping after application since it clings to itself. The multicellular construction provides a

cushion against physical shock. The dressing can be washed and autoclaved. *American Cyanamid Co., Surgical Products Division, Dept. H3, 30 Rockefeller Plaza, New York 20, N.Y.*

Parts and tools cabinet (3D-7)

Manufacturer's description: Of interest to

hospital maintenance and engineering departments are these welded steel units which will stand on any level surface or which may be hung against the wall. For small parts storage, plastic drawers are provided which may be subdivided into three compartments each. Seamless steel drawers are provided for storage of tools such as electric drills, drill bits, drum sanders, and other hand tools. Drawer front label slots provide easy indexing of contents.

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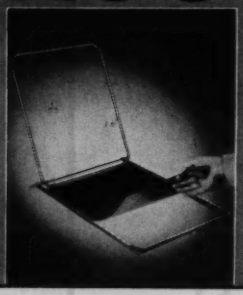

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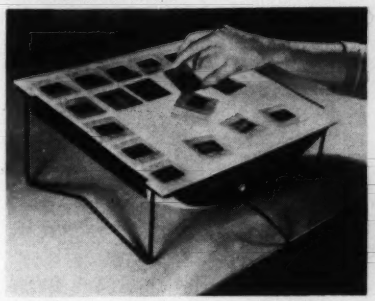
Models are available with 14 to 92 drawers. *Akro-Mils, Inc., Dept. H3, 820 E. Market St., Akron 9, Ohio.*

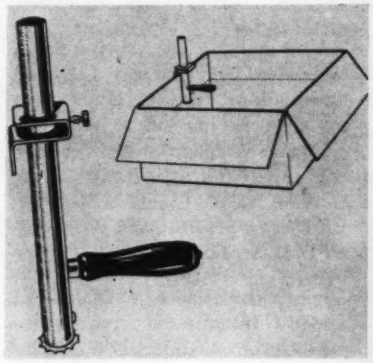
Slide sorter (3D-8)

Manufacturer's description: Slide sorter permits quick viewing of up to 40 35-mm. slides at a time for quick identification and selection. It facilitates the arrangement of slides in any order or continuity desired for screen projection. The complete unit consists of an unbreakable, translucent plastic surface mounted on a sturdy enameled steel stand. Light from a 40-watt lamp assembly is reflected up from a built-in reflector to provide soft, evenly diffused light. *H. E. Geist Co., Dept. H3, 8620 Lorain Ave., Cleveland 2, Ohio.*



Carton sizer (3D-9)

Manufacturer's description: This new aluminum tool makes it possible to re-use odd-size cartons by scoring box walls to the depth desired so sides can be folded to proper size. The unit is made of polished aluminum, with a lifetime scoring wheel. Depth of scoring is controlled by an adjustable depth gauge with set-screw. The whole operation takes seconds and eliminates dangerous cutting or costly special box orders. *Markay Products, Dept. H3, 18 East 11th St., Kansas City 6, Mo.*



Cardiac stimulator (3D-10)

Manufacturer's description: This new unit both stimulates and monitors the heart. An autoclavable, flexible, insulated wire is passed through the chest wall. It is enclosed in a special needle with a diameter of approximately 1½ mm. The wire which pierces the myocardium is extremely thin, only 1/3 of a millimeter, and can

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be left in place for long periods without damaging the heart muscle. The unit is completely transistorized and weighs 1½ lbs. *Atronic Products, Inc., Bio-Medical Div., Dept. H3, One Bala Ave., Bala-Cynwyd, Pa.*

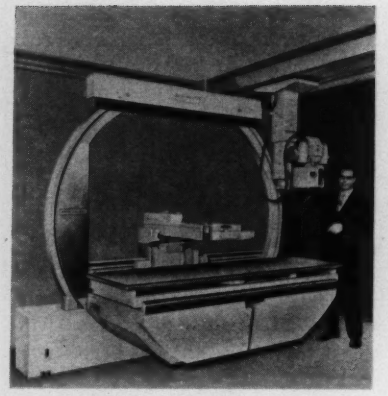
Automatic dishwasher conveyor (3D-11)

Manufacturer's description: The installation is engineered to operate in the smallest amount of floor space and is equipped with an on-off switch

or an automatic intermittent drive switch accessible from any position along the conveyor to handle varying load conditions. Features include: direct loading of dishes to conveyor; automatic prewash, automatic pumped wash and final rinse; unloading directly from conveyor to storage area; visual inspection assuring cleaner dishes; and optional waste disposer unit. *Champion Dish Washing Machine Co., Dept. H2, 311 State St., Erie, Pa.*

Diagnostic x-ray unit (3D-12)

Manufacturer's description: Every function of the unit is so exactly counterbalanced and under such exact and simplified control that its ease of handling allows the radiologist and technician to devote their undivided attention to the patient. One of the features of the unit is an entirely new concept in bilateral overhead tube-hanger design where the radiographic cables are visible only where they attach to the tube unit. The machine is a newly designed spot-film unit



which will retain shutter diaphragm settings regardless of table angulation. *General Electric Co., X-ray Dept. (H3), 4855 W. Electric Ave., Milwaukee, Wis.*

product literature

SEE COUPON, PAGE 58

Automatic rotary presses (3DL-1)—A compilation of information and specifications on a line of rotating presses for laundries. The installation can be made wherever steam and compressed air are available. *Unipress Co., Dept. H3, 2800 Lyndale Ave. So., Minneapolis 8, Minn.*

Caster and wheel manual (3DL-2)—Manual No. 65 carries descriptions, specifications and illustrations of a complete line of casters and wheels including a new nonmarking, electrically conductive wheel. *Darnell Corp., Dept. H3, 12000 Woodruff Ave., Downey, Calif.*

Revolving tray ovens (3DL-3)—A six-page brochure describing a line of automatic revolving tray ovens which both roast and bake, enabling the user to produce "cooked to order" servings with the speed and efficiency of a production line operation. *Baker Perkins, Inc., Dept. H3, Saginaw, Mich.*

Color coded light fixtures (3DL-4)—Four-color brochure gives complete information on a series of light fixtures coded green, yellow, and red to identify traffic lanes, dangerous areas, etc. *Edwin F. Guth Co., Dept. H3, 2615 Washington Blvd., St. Louis 3, Mo.*

Folding wheel chairs (3DL-5)—A 12-page catalogue covering a complete line of folding wheel chairs. The catalogue illustrates and gives specifications on adult and juvenile

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models, mobile chairs, special models for amputees, etc. *Colson Corp., Dept. H3, 7 South Dearborn St., Chicago, Ill.*

Fire protection (3DL-6)—A new brochure, "Modern Fire Protection for Schools, Churches, Hospitals and other Institutions", describes and pictures hazardous spots in institutional buildings and shows the type and size of portable fire extinguisher recommended for best protection. *American LaFrance Institutional Fire Safety, Dept. H3, Elmira, N.Y.*

Gelatine recipe cards (3DL-7)—A free packet of 48 quantity recipe cards. Included are recipes for soups, relishes, pies, cheese cake, and souffles. *Knox Gelatine, Inc., Dept. H3, Johnstown, N.Y.*

Inhalation therapy (3DL-8)—A 64-page, digest-size book that includes sections on fundamentals of inhalation therapy, cylinder and piped gas supply systems and central supply equipment, and inhalation therapy apparatus. The booklet contains illustrations and diagrams of latest equipment for inhalation therapy, with accompanying explanations of how and when the apparatus should be used. *National Cylinder Gas Division of Chemetron Corp., Dept. H3, 840 N. Michigan Ave., Chicago 11, Ill.*

Time and cost record book (3DL-9)—Purpose of this monthly time and cost record book is to assist in determining the cost of owning and operating equipment. Twelve sets of pages are provided for recording, day by day, each month's individual machine expenses for an entire year. An annual summary sheet is provided for noting annual cost figures. Ask for Form 33215. *Caterpillar Tractor Co., Advertising Div., Dept. H3, Peoria, Ill.*

Ice cube machines (3DL-10)—Brochure describes and illustrates three ice cube making units with capacities from 110 to 500 lbs. daily. Patented control is said to guarantee usable, uniform, solid ice cubes under widely varying conditions. Ask for No. SCB-8. *Scotsman, Queen Products Div., Dept. H3, King-Seeley Corp., Albert Lea, Minn.*

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GIANT IN THE BASEMENT —Part 1

Outsize and fuel hungry, typical hospital heating plant is money waster

by CHARLES F. NEERGAARD

In Part I of this two-part article, the author expresses criticism of wasteful heating and ventilating of hospitals, based on his experience as a consultant over a period of many years. He also shows by examples how the extra costs of insulation and double glazing of fixed windows can be liquidated by the lower cost of the heating plant needed.

In Part II, to be published in the February 16 issue of this Journal, the author points to the need for research under exactly controlled conditions into the relative merits of various heating and air conditioning systems and the effect on heating costs of highly efficient thermal barriers.

TWO THESES ON which are staked millions of dollars of original and operating costs of the nation's hospitals are: extravagant overdesign by engineers, and the value of wall and roof insulation and the double-glazing of tight windows.

Why should one hospital with a design temperature of —10°F. heat 137 cubic feet with one square foot of hot water radiation while another, badly overheated with design temperature of 10°F., handle only 47 cubic feet with the same amount of hot water radiation? Both have wall insulation, but not double glazing. The divergence does not lie in the plant requirements of the hospitals themselves, but in the vagaries of engineering.

I. ERRORS ON THE 'SAFE SIDE'

Thirty years ago the building committee of a new hospital spent several months visiting institutions in the East and Midwest. We were frankly critical, looking for things to avoid as well as good ideas to adopt in what we hoped to make the perfect hospital. We were particularly impressed with the large amount of mechanical ventilation the hospitals had and did not use, and above all with the universal overheating.

ENGINEERS DIFFER WIDELY

The engineer, in the absence of stated requirements from the hospital, has always given it what he thought it ought to have. But engineers differ widely on what it takes to do a particular job. Each engineer seems to follow a customary routine of his own and usually errs on the safe side, which usually means excesses in boiler capacity, factors of safety, breakdown reserves, automatic controls, and refinements that the average plant engineer cannot or does not keep tuned up. The result is that in far too many plants, year after year, operating costs of the mechanical plant grossly exceed limits of economy.

In designing a 250-bed hospital and 160-unit nurses' home located in the Midwest, engineers, looking ahead 10 or 15 years, had anticipated future expansion and installed at the start 1000 boiler horsepower, ample to heat the ultimate 500-bed hospital and nurses' home and a lot of "all outdoors".

Each of the 500 h.p. boilers had a capacity of 16,000 lb. of steam per hour. For the original buildings, the maximum peak steam load required for services and heating in zero weather was 10,000 pounds per hour or approximately the capacity of a 300 h.p. boiler. The steam requirements, checked by meter in the late afternoon when the outside temperature was 5°F. showed a boiler load of 230 h.p. Next morning, when the laundry, sterilizers, kitchen, and hot water loads were on, the meter showed a total boiler load of 280 h.p.

In other words, in zero weather only 60 per cent of the capacity of one boiler was required. For at least half the year the daytime load was only 12 per cent of the rating of one boiler. The load at

Charles F. Neergaard, retired hospital consultant, was formerly associated with the firm of Neergaard, Agnew, Craig & Westermann, New York and Toronto, Ontario.

night and on Sundays and holidays was 400 pounds of steam, which would be supplied by a 12 h.p. boiler.

MAJOR SAVINGS POSSIBLE

In my experience there is no department of the hospital which offers such opportunities for major savings as does the mechanical plant. If there is waste in the boiler room some other department has to be penalized. Once an extravagant plant is finished little can be done about it.

I have known committees to spend fewer *minutes* considering and approving a set of mechanical plans involving the expenditure of several hundred thousand dollars, which will bulk large in the budget for the life of the building, than they later spend *hours* in selecting hardware and discussing color schemes.

There are three basic weaknesses in such planning:

1. The architect recommends a consulting engineer, or has one of his own, and the plant is designed following long accepted practices, formulas and calculations that are not always checked as to how well they have worked in the past.

2. The average building committee, lacking experience in a highly technical field, accepts the recommendations of its architect and engineer. It rarely attempts to verify the facts presented, to question the theories, or check on the assumptions. Yet in the end it pays the bills.

3. The hospital as an industry has never analyzed precise needs and formulated definite standards and performance specifications for the many different elements in its mechanical services.

There are four things basically wrong with heating plants:

1. *Too much radiation and too many radiators.* Heat requirements for zero degree temperature needs can be roughly estimated at a ratio of one square foot of radiation to 80 cubic feet of space, and half that if the building is properly insulated. In a group of five hospitals, three located in northeastern United States and two in Canada, the number of cubic feet of space to each square foot of radiation provided ranges from 107 to 200. All these hospitals have insulated walls and windows.

There is a revered 18th Century tradition which calls for radiation under every window. In one hospital I counted 103 unnecessary radiators, including 13 in the kitchen and one in the central sterilizing room seven feet from the autoclaves; in another, 12 radiators, with five and a unit heater in the laundry, three in each operating and delivery room, and two in the kitchen storeroom. Considering the cost of hooking up and valving each unit, a group of rarely used radiators scattered around a hospital represents a considerable sum of wasted money.

2. *Steam or vapor radiators are either too hot or too cold.* In my experience, neither steam nor vapor heat is satisfactory for a hospital. Circulating hot water in a properly zoned closed system is simple, easily controlled, comfortable and requires no larger radiators than does steam. Aside from panel heating (to be discussed later), hot water is the most nearly ideal and most economical medium for hospital heating.

3. *Excessive boiler capacity.* The size of the boilers is based on the heating load and steam requirements for hot water supply, laundry, kitchen, and sterilizers and air conditioning. The steam requirements are a fluctuating part-time demand representing at most but one-third of the total boiler load during the summer months.

4. *Boilers run at one-third or less capacity for half the year, whereas economical operation is with an overload.* Boiler manufacturers recommend that for highest efficiency and most economical operation a boiler may be run about 150 per cent of its rated capacity.

BOILERS TOO BIG

Inevitably engineers specify a standby boiler sufficient to carry the entire load, yet for six months of the year little or no heat is required and steam consumption is approximately 30 per cent of the winter load. On the 50 Saturdays, Sundays and holidays when the laundry is shut down, only approximately 12 per cent of the steam is required.

The U. S. Public Health Service has stated:[1]

"If two 100 h.p. boilers were used to generate heat and steam and provide breakdown service for a 100-bed hospital, it would be necessary to operate during the summer months at less than one-third rated capacity. For a hospital of this size a 70 h.p. steel hot water heating boiler and two 40 h.p. 125-lb. boilers will under most conditions meet all requirements, save the cost of 50 boiler horsepower, and operate most efficiently. The first cost of a hot water heating boiler is less than that of a high-pressure boiler and the maintenance charges are less, as it will not corrode and requires no pumps. As the hot water heating boiler can be reconditioned in the summer, a breakdown should not be anticipated; this contingency can be taken care of by operating the two steam boilers at 125 per cent rated capacity and using a hot water converter for the heating system."

This type of combined low and high pressure boiler plant has proved successful in a large number of hospitals and merits more general adoption.

VENTILATION SYSTEMS WASTEFUL

Mechanical ventilation has for years been another of the big hidden leaks in hospital construction and operation budgets. Overventilation has persisted in varying degrees since around the turn of the century, when millions of dollars were wasted in plenum systems of ventilation which filled excess cubage with a myriad of ducts and required some 40 boiler horsepower to heat each 10,000 cfm of induced air. I have seen the remains of many of these systems in hospitals but never one in operation. Many of these old hospitals, when they found how much it cost to operate the big fans and how really unnecessary the additional ventilation was, shut down the fans, but year after year they still pay standby charges for electricity and overheat the building with the added boiler capacity.

The average hospital needs effective exhaust fans only for toilets and a few special departments to remove steam and odors and to keep the air in motion. Given plenty of windows, a forced fresh air system is rarely if ever justified.

Some plans call for the introduction of large amounts of fresh air where only exhaust is needed. This adds materially to the steam load, as it removes large volumes of heated air which must be replaced by cold air, which must be heated.

II. HEAT FOR ALL OUTDOORS

At the same time the budgets of the nation's hospitals are being strained paying for too much heat and ventilation, another strain is felt from the effects of too little provision for keeping heat within the walls. Specifically, insulation and double glazing of tight windows.

A few designers have been using insulation generally for more than 25 years. But in most instances, where insulation has been neglected, hospitals are wasting thousands of dollars each year. While the better walls and double-glazed windows are more expensive, we have found in many hospitals that the savings which the engineer can make in safely reducing the size of the boilers and radiators can substantially offset this. Thus, the over-all building budget is not increased, while the annual fuel bill, which has been cut in half, yields big dividends for the life of the hospital.

Complete insulation cuts costs five ways:

1. It can cut the size of the radiation in half.
2. It can cut the size of the heating boiler in half.
3. It can cut the fuel bill in half for the life of the building.
4. It cuts patient and personnel discomfort from cold walls and windows.
5. It cuts the fee for the consulting engineer.

A sixth advantage of insulation is summer comfort. In tests in hospitals with old and new wings, recording thermometers showed that the insulated building averages 8° cooler than an uninsulated structure, and this without air conditioning.

A CANADIAN OPINION

James Govan, a Toronto architect who pioneered with insulation, has stated: "Canadian owners and architects should know that there is absolutely no need for increased capital expenditure to provide increased thermal capacity because its cost can and should come out of the reduction in expenditure for the heating plant provided".

According to the Public Health Service:[2] "Heat requirements at zero degree temperature may be roughly estimated as 1 square foot of radiation to 80 cubic feet of space heated for uninsulated buildings.

"When the walls are well insulated the size of the heating boilers and radiators can be reduced approximately 25 per cent; if, in addition, the windows are effectively double glazed, 50 per cent, or approximately 1 square foot of radiation to 160 cubic feet of space."

Insulation of walls and roofs is general in small houses, and, to a limited extent, double glazing. But the acres of walls and hundreds of windows in all types of multistory buildings are rarely protected against heat loss.

Somehow, designers and engineers of hospitals, schools, and multiple housing projects do not realize that they can reduce heating and operating costs for the life of the building at no extra original construction cost (the cost of insulation and double glazing can be absorbed by the reduced boiler plant and radiation).

FIGURES PROVE SAVINGS

Some 20 years ago I was consultant on the Washington County Hospital at Hagerstown, Md. I recommended the adoption of insulation, having discovered its values in an earlier Canadian project. The building committee approved and we put up the first multistory building of any type in the country that was completely insulated and double glazed. The engineer reduced his hot water radiation by half, using 1 square foot of radiation to every 160 cubic feet of space to be heated, instead of his usual 1-to-80 ratio without insulation. The builder, after careful cost analyses, reported that the savings in the heating plant offset the extra cost of the better walls and windows.

Ever since then I have urged the use of insulation on all hospital projects. I have run into two obstacles: the skepticism of the architects and engineers and, when insulation was adopted, the almost inevitable tendency to overdesign the heating plant.

12 HOSPITALS STUDIED

A recently published study[3] of mechanical engineering patterns in hospitals presented data on 12 hospitals, only four of which approached the formula of 1 square foot of radiation to 160 cubic feet of space for a zero degrees design temperature. The eight others, four of them in Canada, show ratios ranging from 1-to-113 to 1-to-43, the latter in a building excessively ventilated and designed for future air conditioning. Each of the eight buildings is overheated and wastes large amounts of fuel. In the four conservatively engineered hospitals, the capital cost thesis held good: there was no increase in the over-all building budget. The economies of operation in the insulated and conservatively heated buildings are significant.

Data are available for mechanical plant operation of 20 large hospitals, as presented by McNichol Roswell and Co., auditors for 62 hospitals. The average cost was $1.10 per patient day. Five of the 20, uninsulated, range from $1.37 to $1.82 per patient day; our eight insulated hospitals, four in Canada, show a spread from $.65 to $1.19 per patient day. The excessively ventilated hospital mentioned just above spent $2.06. In Canada at the time of the tabulation, fuel oil cost $.106 against $.06 in the United States. A Glens Falls, N.Y., hospital, which had the lowest figure, $.65 per patient day, was well insulated but not double glazed. A highly efficient and flexible three-unit boiler plant contributed to the economy.

Savings of $900,000 a year, equivalent to 4 per cent interest on an endowment of $22.5 million, would have resulted if all 20 hospitals had been built to operate as economically as the Glens Falls plant. ■

(To be concluded)

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1. *Functional Basis of Hospital Planning* (Mechanical Section). Division of Hospital Facilities, Public Health Service, Washington, D.C.
2. *Ibid.*
3. Mechanical engineering critique. *Progressive Architecture*, Feb. 1958.

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GOLDEN GATE BAKED FIGS

DRIED FRUIT CAN WHET APPETITES

by adding variety and flavor interest

by ILMA LUCAS DOLAN

THE ANCIENT art of drying fruit has come down through the ages—with variations. Dehydration with temperature and humidity controls has almost entirely displaced sun drying in the case of prunes. As a result, the fruit has a more natural flavor and is more uniform.

To many, "dried fruit" means prunes and raisins, and while these fruits are by far the largest crop, the dietitian knows the importance of dried apricots, peaches, pears, figs and apples in the diet.

The intense flavor of dried fruits doesn't just happen. The fine flavor dominates because the fruit is harvested when it is fully ripe. Prunes, for example, are never picked. They are harvested only after they fall to the ground from their own weight. Not only flavor but fruit sugar is fully developed during this long ripening period. Fruit sugar increases as much as 30 per cent, as shown in Table 1, below.

The best method of cooking dried fruits is quick and simple. Rinse fruit, cover with water and cook until tender. Newer processing methods have long since outdated the time-consuming soaking routine. Cooked fruits are more plump and cooking liquid has much more flavor when the fruits are allowed to stand in their liquid for several hours.

With the exception of dried figs, sweeten cooked fruit during the last minutes of cooking. Sweeten figs about 15 minutes before the end of cooking time.

Dried fruits, moreover, are adaptable to many uses on hospital menus. As a breakfast fruit, as a meat accompaniment, as an ingredient in sandwich fillings, salads, stuffings, pies, cakes, puddings, yeast breads, quick bread, rolls, coffee cakes, cookies, cookie bars, and frozen desserts, dried fruits give interesting and palatable variety to hospital meals.

Prunes atop ready-to-eat or cooked cereal, and raisins cooked in cereal provide a new look and a different taste. Stewed prunes or baked figs accented with stick cinnamon or paper-thin slices of lemon or orange are exceptionally delicious. Here is the recipe for 24 servings of Golden Gate baked figs:

GOLDEN GATE BAKED FIGS
(24 servings)

- **3 lbs. dried figs**
- **3 pts. water**
- **3 sticks cinnamon**
- **1 small lemon, thinly sliced**
- **½ tsp. salt**
- **1½ c. sugar**

1. Clip stems from figs. Place figs, water, cinnamon, lemon slices and salt in shallow baking pan and let stand 4 or 5 hours or overnight.
2. Add sugar, cover and bake in a moderate oven (350° F.) for 45 to 50 minutes or until plump and syrup is thickened.
3. Serve figs warm or cold; plain or topped with table or sour cream.

Table I—Comparison of Sugar Content of Dried and Fresh Fruit

FRUIT	Per Cent Sugar in Dried Fruit	Per Cent Sugar in Fresh Fruit
Apples	54	11
Apricots	46	10
Figs	56	16
Peaches	43	9
Pears	39	9
Prunes	44	13
Raisins	66	15 (grapes)

SALAD, DESSERT RECIPES

Dried fruit in salads, or combined with seasonal fresh fruit, can make salad enthusiasts out of the most reluctant patients. One good example is raisin apple slaw. Here is the recipe:

RAISIN APPLE SLAW
(24 servings)

- **1½ c. mayonnaise**
- **1½ c. sour cream, commercial**
- **⅓ c. vinegar**
- **Salt to taste**
- **2 tsp. mustard (optional)**
- **1 c. grated American cheese (optional)**
- **2-3 c. raisins, light or dark**
- **3 qts. cabbage, shredded**
- **3 or 4 large apples, unpeeled (sliced or diced)**

1. Combine mayonnaise, sour cream, vinegar, salt, mustard and cheese.
2. Rinse and drain raisins; toss with cabbage and apple slices until distributed.
3. Add dressing and toss lightly

Ilma Lucas Dolan is dietitian for the California Dried Fruit Research Institute, San Francisco.

RAISIN APPLE SLAW

RAISIN RICE CUSTARD

CIDER SPICED PRUNES

to mix.

Dried fruits have a place on the hospital dessert menu, too. We cannot forget the old-time favorite, raisin rice custard. Here is the recipe for 24 servings:

RAISIN RICE CUSTARD
(24 servings)

1½ c. raisins, light or dark
2½ qts. milk
10 eggs
1¼ c. sugar
1 tsp. salt
2 tsp. vanilla
1¼ qts. rice, cooked

1. Rinse and drain raisins.
2. Scald milk.
3. Beat eggs with sugar, salt and vanilla.
4. Stir in rice, raisins and milk. Turn into shallow baking pan and set in pan of hot water.
5. Bake in moderate oven (350° F.) 1 hour, or until set.

No upside-down cake tastes better or looks more attractive than a prune and dried apricot duo. Raisin faces in sugar cookies make a hit on the children's ward, as does dried fruit served as it comes from the package—clean, easily served, delicious and nutritious. Children love the chewy texture.

Strips of partially cooked dried apricots and pears rolled in sugar make a quick and easy candy for holiday trays that's different and not too sweet.

Spiced dried fruit—figs, peaches, pears, apricots dress up salad and sandwich plates; give an added touch of glory. They may also add zest and eating pleasure to any entree. One good example is cider spiced prunes with fried chicken. Here is the recipe.

CIDER SPICED PRUNES
(2 qts.)

1½ lbs. prunes
1 qt. apple cider
1 pt. burgundy wine
⅔ c. brown sugar (packed)
4 cinnamon sticks (3-inch)
2 tsp. whole cloves
½ tsp. salt

1. Rinse prunes. Combine with all remaining ingredients. Cover, bring to boil and simmer for 20 to 30 minutes.
2. Remove from heat and let stand until cool.
3. Serve as garnish with meat or poultry; or as a not-too-sweet dessert. ■

NOTES AND COMMENT

Dessert, entree recipes featured in menus

Recipes for two dessert items and fish entree that are favorites with patients at Mountainside Hospital, Montclair, N.J., are presented here through the courtesy of Mrs. Elizabeth C. Downes, director of the hospital's dietary department. Mrs. Downes has featured these items in her spring cycle menu beginning on p. 74 of this issue.

Here are the recipes:

SHRIMP CREOLE
(50 scant servings)

4½ lbs. tomatoes, canned
1½ oz. salt
1 lb. green peppers, chopped
12 oz. onions, chopped
1 lb. celery, chopped
1½ tsp. mixed spices
1 ¾ tsp. pepper
3½ oz. oil
4½ lbs. shrimp

1. Combine all ingredients, except shrimp, and braise in the oil until vegetables are tender.
2. Add shrimp and heat through.
3. Serve on steamed rice.
4. Yield is 1½ gal. or 50, ½ c. servings.

LEMON MERINGUE PUDDING
(50 servings, 4 oz. each)

10 oz. butter or margarine
10 oz. flour, pastry
3 ¾ lbs. sugar
1½ tsp. salt
1 lb. egg yolks
1 ⅛ lbs. lemon juice
2 ⅔ oz. lemon rind
4 lbs. milk
1½ lbs. egg whites

1. Cream the butter or margarine thoroughly.
2. Mix the flour, sugar and salt together. Add to the creamed mixture and mix until creamy.
3. Beat the egg yolks well. Add. Blend thoroughly.
4. Add lemon juice, rind and milk. Mix.
5. Beat the egg whites until stiff (not dry) and fold into the batter.
6. Raw yield is 12¾ lbs. Scale 8½ lbs. into greased pan (11 by 19 by 2¼) and 4¼ lbs. into greased pan (8½ by 15 by 2½).
7. Bake at 350° F. for approximately 30 minutes. This pudding bakes quickly.
8. Yield is 12½ lbs. Cut contents of large pan into 32 pieces, and of small pan into 18 pieces.
9. Approximate size of serving is 2½ by 2¾ by 1 inch.
10. Chill and serve with whipped cream.

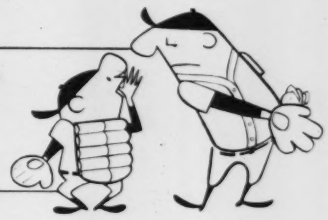
CORNFLAKE MACAROONS
(50 cookies, 3 inch)

4 oz. butter
6 oz. brown sugar
8 oz. white sugar
3½ oz. eggs
3½ oz. nuts (pecans)
3 oz. shredded cocoanut
7 oz. cornflakes

1. Cream butter and sugars thoroughly.
2. Beat in eggs. Stir in nuts, cocoanut and cornflakes.
3. Yield will be 2 lbs. batter or 50 cookies (2/3 oz.).
4. Using a tablespoon, drop batter onto sheets lined with waxed

paper and bake in a moderate oven at 350° F. for 10 minutes. Note: Store in a closed container if kept more than a day. ■

Spring Cycle Menu for the East



THE 21-DAY selective spring cycle menu and market orders for perishables on pages 74-76 are designed for hospitals in eastern United States. These menus, for use in March, April, and May, feature foods popular in the East, including many entrees.

Menus in this issue are the third in a four-part series of spring cycle menus. Spring cycle menus for Midwest hospitals appeared on pages 70, 72 and 73 of the January 1 issue of this Journal. The South-Southwest spring menus were in the January 16 issue. North-Northwest menus will appear February 16.

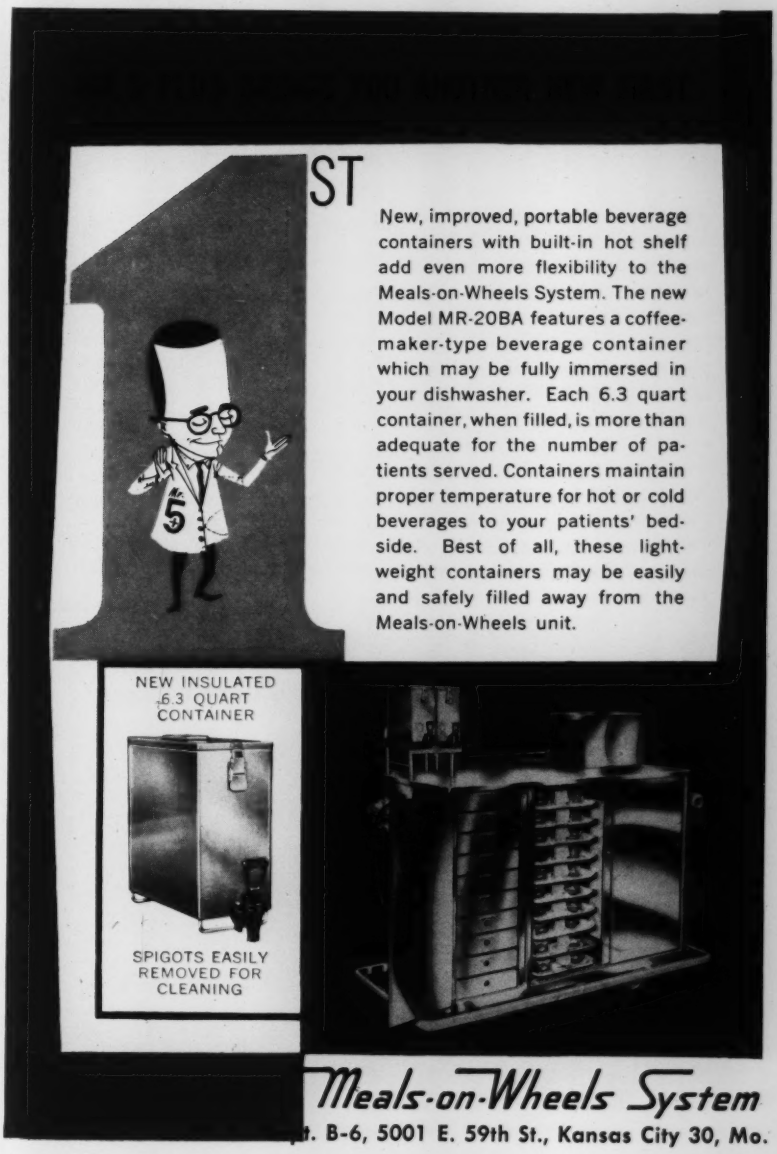
Menus in this issue feature a choice of entree, vegetable, salad and dessert for the noon and night meals. Two cereals and two fruits are offered on breakfast menus.

Since one of the choices offered is suitable for modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items designates their suitability for full or normal diets; foods acceptable on soft and other modified diets are labeled (S). The letters (FS) mean the item can be used on both full and soft diets.

The winter cycle menus, published in the October and November 1958 issues of this Journal, are for use during February. The Midwest and South-Southwest cycle menus appeared in the October 1 and 16 issues, respectively. The November 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

The market order accompanying each week's menu lists the meats, seafood, poultry and fresh and frozen fruits and vegetables needed in producing the menu for a 50-bed hospital. The order includes precut meats, roasts and seafoods, eviscerated poultry, and other partly prepared items. Amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily compute market orders.

Another feature of this cycle menu service is a standard storeroom inventory—a list of supplies that a 50-bed hospital should have on hand at the beginning of each 21-day cycle. The list includes cereals and farinaceous products, and canned, dried, preserved and pickled items. The inventory is available on request from the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill.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1st WEEK EAST SPRING SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

—prepared by Mrs. Elizabeth C. Downes, director, dietary department, Mountainside Hospital, Montclair, N.J.

	breakfast	noon	night
monday	Stewed Prunes **or** Orange Juice Whole Wheat Cereal **or** Puffed Rice Cereal French Toast with Syrup	Consomme with Rice Grilled Bacon—Spanish Omelet **or** Broiled Loin of Lamb Chop (FS) Duchess Potato (FS) Mixed Garden Vegetables **or** Glazed Carrots (FS) Chef Salad—French Dressing **or** Pineapple and Cherry Salad Butter Almond Ice Cream (F) **or** Lemon Gelatin with Whipped Cream (S)	Vegetable Juice Chicken Fricassee (FS) **or** Smoked Tongue with Raisin Sauce Mashed Potato (FS) Green Beans (FS) **or** Brussels Sprouts Pear and Currant Jelly Salad **or** Head Lettuce Salad—French Dressing Gingerbread with Whipped Cream **or** Applesauce (FS)
tuesday	Orange Halves **or** Apple Juice Farina **or** Bran Flake Cereal Raisin Toast Bacon	Scotch Barley Soup Beef Pattie with Mushroom Gravy (FS) **or** Cheese Souffle—Jelly Baked Potato (FS) Sliced Beets **or** Buttered Wax Beans (FS) Cabbage and Green Pepper Salad **or** Grapefruit, Banana and Nut Salad Chocolate Pie with Whipped Cream (F) **or** Orange Sherbet (S)	Pineapple-Apricot Juice Veal Chop **or** Broiled Fillet of Haddock—Lemon Slice (FS) Parsley Potato Buttered Peas (FS) **or** Stewed Tomato Tossed Salad—French Dressing **or** Assorted Relishes Vanilla Ice Cream with Butterscotch Sauce (FS) **or** Peach Half in Syrup
wednesday	Banana **or** Blended Fruit Juice Wheat Farina **or** High Protein Cereal Soft Cooked Egg Soft Roll	Tomato Juice Tunafish Salad Plate **or** Roast Beef with Gravy (FS) Lyonnaise Potato (F) Asparagus Tips (FS) **or** Baby Lima Beans Apricot and Cocoanut Salad **or** Head Lettuce—French Dressing Sugar Cookies (FS) **or** Bing Cherries in Syrup	Cream of Mushroom Soup Roast Loin of Pork with Gravy **or** Broiled Halibut—Lemon Slice (FS) Baked Potato (FS) Buttered Spinach **or** Fresh Sliced Carrots (FS) Molded Fruit Salad **or** Celery-Pimiento Cheese Salad Baked Custard (FS) **or** Pineapple Sherbet
thursday	Applesauce **or** Grapefruit Juice Oatmeal **or** Cornflakes Broiled Ham Hard Roll	Vegetable Soup Eggs a la King on Toast (FS) **or** Veal Cutlet—Catsup Whipped Potato (FS) Green Beans (FS) **or** Kernel Corn Orange and Date Salad **or** Cole Slaw Lemon Meringue Pudding (FS) **or** Coffee Ice Cream	Grape Juice Roast Turkey with Giblet Gravy (FS) **or** Broiled Liver and Bacon Creamed Potato (FS) Broccoli—Lemon Sauce **or** Buttered Peas (FS) Cranberry Relish **or** Heart of Lettuce—Russian Dressing Frosted Cupcake (FS) **or** Purple Plums in Syrup
friday	Stewed Apricots **or** Orange Juice Whole Wheat Cereal **or** Puffed Wheat Cereal Soft Cooked Egg Blueberry Muffin	Manhattan Clam Chowder Sea Food Au Gratin **or** Broiled Lamb Pattie (FS) Buttered Rice (FS) Mixed Garden Vegetables **or** Buttered Beets (FS) Chef Salad—French Dressing **or** Pear and Cottage Cheese Salad Vanilla Pudding with Toasted Cocoanut **or** Chocolate Ice Cream with Marshmallow Sauce (FS)	Pineapple-Grapefruit Juice Pot Roast of Beef with Gravy **or** Broiled Salmon Steak—Lemon Slice (FS) Mashed Potato (FS) Buttered Lima Beans **or** Spinach (FS) Tomato Aspic Salad **or** Waldorf Salad Spice Cake (F) **or** Peach Half in Syrup (S)
saturday	Half Grapefruit **or** Prune Juice Farina **or** Shredded Wheat Cereal Scrambled Egg Cinnamon Toast	Fruit Juice Cocktail Broiled Minute Steak (FS) **or** Macaroni and Cheese Baked Potato Stewed Tomato **or** Buttered Peas (FS) Hearts of Lettuce—French Dressing **or** Orange and Nut Salad Fruit Gelatin—Whipped Cream (S) **or** Apple Crisp with Cream (F)	Split Pea Soup Roast Leg of Lamb with Gravy (FS) **or** Corned Brisket of Beef Parsley Potato Buttered Cabbage **or** String Beans (FS) Pineapple and Raisin Salad **or** Assorted Relishes Lemon Meringue Pie **or** Neopolitan Ice Cream (FS)
sunday	Orange Halves **or** Apricot Juice Wheat Farina **or** Puffed Rice Cereal Grilled Bacon Kuchen Bread	Consomme with Noodles Roast Chicken with Gravy (FS) **or** Baked Ham Mashed Sweet Potatoes (FS) Brussels Sprouts **or** Buttered Wax Beans (FS) Romaine—Chiffonade Dressing **or** Grapefruit and Avocado Salad Vanilla Ice Cream **or** Cream Tapioca Pudding (FS)	Vegetable Juice Broiled Sweetbreads and Mushrooms **or** Cubed Steak with Natural Gravy (FS) Baked Potato (FS) Fresh Sliced Carrots **or** Asparagus Tips (FS) Cottage Cheese and Green Pepper Salad **or** Mixed Fruit Salad—Whipped Cream Dressing Brownies **or** Pear Halves in Syrup (FS)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket Corned	U. S. Good	7 lbs.	20
Ground Beef	U. S. Good, 5 lb. pkg.	20 lbs.	
Liver	Steer, sliced	5 lbs.	20
Roast, Sirloin (B.R.T.)	U. S. Choice	27 lbs.	
Round (Bottom)	U. S. Standard	7 lbs.	20
Steaks, Minute	U. S. Choice, 4 oz. each	35 lbs.	140
Tongue	No. 1	7 lbs.	
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	30 lbs.	80
Ground, Shoulder	U. S. Good	20 lbs.	80
Leg (B.R.T.)	U. S. Choice, yearling	20 lbs.	60
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Ham, (Pullman)	Ready-to-eat	30 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	
VEAL			
Chops, Shoulder	U. S. Good, 5 oz. each	7 lbs.	
Cutlets	U. S. Good, 4 oz. each	10 lbs.	40
FISH			
Haddock	Fillets, skinless	15 lbs.	
Halibut	Steaks, 5 oz. each	18 lbs.	
Salmon	Red, steaks, 5 oz. each	18 lbs.	
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	60 lbs.	
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	45 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	50 lbs.	
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	6 only	
Bananas	Ripe	25 lbs.	
Cranberries	1 lb. bag	3 lbs.	
Grapefruit	Seedless, 70s	1 box	
Lemons		1 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	White	6 stalks	
Cucumbers		1 doz.	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Peppers, Green		1½ doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine		6 heads	
FROZEN FRUITS			
Apples	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	25 lbs.	150
Beans, Green	Cuts, 2½ lb. pkg.	35 lbs.	210
Beans, Lima	Small, green, 2½ lb. pkg.	5 lbs.	30
Beans, Wax	Cuts, 3½ lb. pkg.	30 lbs.	180
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	35 lbs.	210
Spinach	Chopped, 2½ lb. pkg.	12½ lbs.	75
Vegetables, Mixed	2½ lb. pkg.	5 lbs.	30

PLEASE CUT ALONG THIS LINE

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

2nd WEEK EAST SPRING SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

—prepared by Mrs. Elizabeth C. Downes, director, dietary department, Mountainside Hospital, Montclair, N.J.

	breakfast	noon	night
monday	Stewed Prunes **or** Blended Juice Oatmeal **or** Bran Flake Cereal Soft Cooked Egg	Chicken-Noodle Soup Welsh Rarebit on Toast (FS) **or** Swiss Steak with Gravy Oven-Browned Potato Buttered Broccoli **or** Julienne Green Beans (FS) Head Lettuce Salad—French Dressing **or** Spiced Beet Salad Peeled Apricot Halves in Syrup (FS) **or** Cherry Vanilla Ice Cream	Cream of Celery Soup Lamb Stew with Dumpling **or** Roast Leg of Veal with Gravy (FS) Buttered Rice (FS) Grilled Tomato **or** Buttered Peas (FS) Pear and Mint Jelly Salad **or** Watercress Salad Butterscotch Pudding with Whipped Cream (FS) **or** Pineapple Upside-down Cake
tuesday	Banana **or** Grapefruit Juice Whole Wheat Cereal **or** Corn Flakes Scrambled Egg Raisin Toast	Consomme Julienne Smoked Tongue with Raisin Sauce **or** Hot Roast Beef Sandwich with Gravy (FS) Steamed Sweet Potato (FS) Buttered Cauliflower **or** Asparagus Tips (FS) Peach and Prune Salad **or** Tossed Salad—French Dressing Chocolate Pudding with Whipped Cream (FS) **or** Fruit Cup	Cream of Mushroom Soup Baked Mackerel—Sliced Lemon **or** Roast Turkey with Giblet Gravy (FS Whipped Potato (FS) Baby Lima Beans **or** Buttered Carrots (FS) Molded Cranberry Salad **or** Head Lettuce Salad—Russian Dressing Coffee Ice Cream (FS) **or** Apple Pie
wednesday	Half Grapefruit **or** Apple Juice Farina **or** Shredded Wheat Cereal Poached Egg on Toast	Cream of Tomato Soup Sautéd Chicken Livers with Mushrooms **or** Broiled Fillet of Haddock (FS) Parsley Potato (FS) Mixed Garden Vegetables **or** Spinach (FS) Asparagus and Pimiento Salad **or** Orange and Watercress Salad Old Fashioned Bread Pudding (FS) **or** Lemon Sherbet	Fruit Juice Cocktail Roast Beef with Gravy (FS) **or** Broiled Scallops with Tartar Sauce Mashed Potato (FS) Stewed Corn **or** Julienne Green Beans (FS) Chef Salad—French Dressing **or** Assorted Relishes Cheese Cake **or** Peach Halves in Syrup (FS)
thursday	Stewed Apricots **or** Orange Juice Oatmeal **or** Ready-to-Eat Malt Flake Cereal Soft Cooked Egg—Bacon Hard Roll	Cranberry Juice Cocktail Turkey Pie **or** Cubed Steak with Natural Gravy (FS) Buttered Rice (FS) Sliced Beets **or** Buttered Wax Beans (FS) Head Lettuce Salad—French Dressing **or** Pear and Cherry Salad Vanilla Ice Cream with Raspberry Sauce **or** Floating Island (FS)	Vegetable Soup Pork Chop **or** Roast Leg of Lamb with Gravy (FS) Oven Browned Potato (FS) Baked Acorn Squash (FS) **or** Buttered Peas Cole Slaw **or** Lime and Fruit Salad Cocoanut Cake **or** Applesauce (FS)
friday	Orange Halves **or** Pineapple Juice Wheat Farina **or** Puffed Rice Cereal Scrambled Egg Soft Roll	Boston Clam Chowder (F) Shrimp Creole **or** Roast Leg of Veal with Gravy (FS) Baked Potato (FS) Asparagus Tips (FS) **or** Baby Lima Beans Cottage Cheese and Pimiento Salad **or** Banana and Nut Salad Cherry Pie **or** Raspberry Gelatin (FS)	Grape Juice Chicken Fricassee (FS) **or** Baked Bluefish with Lemon Butter Whipped Potato (FS) Brussels Sprouts **or** Fresh Sliced Carrots (FS) Tossed Salad—French Dressing **or** Waldorf Salad Apricot Whip (FS) **or** Vanilla Ice Cream with Chocolate Sauce
saturday	Stewed Prunes **or** Grapefruit Juice Whole Wheat Cereal **or** Cornflakes Poached Egg	Tomato Juice Broiled Minute Steak (FS) **or** Cheese Omelet Parsley Potato Buttered Beets **or** Green Beans (FS) Head Lettuce Salad—French Dressing **or** Jellied Fruit Salad Orange Sherbet (FS) **or** Devils Food Cake	Scotch Barley Soup Baked Ham **or** Broiled Lamb Pattie (FS) Mashed Sweet Potato (FS) Boiled Onions and Peas **or** Spinach (FS) Chopped Carrot and Egg Salad **or** Romaine Salad with Russian Dressing Tapioca Pudding with Fruit Sauce (FS) **or** Royal Anne Cherries in Syrup
sunday	Banana **or** Apricot Juice Farina **or** Bran Flake Cereal Scrambled Egg—Bacon Kuchen Bread	Cream of Pea Soup Roast Beef with Gravy (FS) **or** Roast Loin of Pork with Gravy Buttered Noodles (FS) Buttered Broccoli **or** Wax Beans (FS) Chef Salad—French Dressing **or** Stuffed Celery Pineapple Sundae **or** Lemon Meringue Pudding (FS)	Chilled Blended Juice Creamed Turkey (FS) **or** Veal Chop Baked Potato (FS) Asparagus Tips (FS) **or** Mixed Garden Vegetables Tomato and Lettuce Salad **or** Peach and Raisin Salad Cornflake Macaroons **or** Baked Apple (FS)

(F)—Full Diet (S)—Soft Diet FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

PLEASE CUT ALONG THIS LINE

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Roast, Sirloin (B.R.T.)	U. S. Choice	80 lbs.	
Steaks, Cubed	U. S. Choice, 4 oz. each	40 lbs.	160
Steak, Swiss	U. S. Good, 4 oz. each	10 lbs.	40
Tongue	No. 1	15 lbs.	
LAMB			
Ground, Shoulder	U. S. Good	15 lbs.	60
Leg (B.R.T.)	U. S. Choice, yearling	20 lbs.	60
Stew	U. S. Good	5 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Chops, Loin	Grade A, 4 oz. each	5 lbs.	20
Ham, (Pullman)	Ready-to-eat	7 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	15 lbs.	
VEAL			
Chops, Shoulder	U. S. Good, 5 oz. each	7 lbs.	
Leg (B.R.T.)	U. S. Good	50 lbs.	
FISH			
Bluefish		15 lbs.	
Haddock	Fillets, skinless	20 lbs.	80
Mackerel		5 lbs.	20
Scallops		3 qts.	

Item, Specifications, Amounts & No. of Servings		
Shrimp	26-28-1 lb.	5 lbs.
POULTRY		
Fowl (Eviscerated)	Grade A, 5 lb. av.	60 lbs.
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	85 lbs.
Livers, Chicken	1 lb. pkg.	8 lbs.
FRESH FRUITS		
Apples	Jonathan, 113s	2 boxes
Bananas	Ripe	40 lbs.
Cranberries	1 lb. bag	3 lbs.
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Oranges	176s	1 box
FRESH VEGETABLES		
Carrots	Topped, bag	50 lbs.
Celery	White	1 doz. stalks
Cucumbers		1 doz.
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Potatoes, Sweet	Hamper	50 lbs.
Potatoes, White	Bag No. 1	400 lbs.

Item, Specifications, Amounts & No. of Servings			
Radishes	Bunch	1 doz.	
Romaine		6 heads	
Squash, Acorn		30 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Watercress	Bunch	1½ doz.	
FROZEN FRUITS			
Apples	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
Cherries	5-1 sugar, pitted, 8 lb. can	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	40 lbs.	240
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Julienne, 2½ lb. pkg.	25 lbs.	150
Beans, Lima	Small, green, 2½ lb. pkg.	5 lbs.	30
Beans, Wax	Cuts, 2½ lb. pkg.	30 lbs.	180
Broccoli	Stems and buds 2½ lb. pkg.	5 lbs.	30
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	15 lbs.	90
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	150
Vegetables, Mixed	2½ lb. pkg.	5 lbs.	30

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

3rd WEEK EAST SPRING SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

—prepared by Mrs. Elizabeth C. Downes, director, dietary department, Mountainside Hospital, Montclair, N.J.

	breakfast	noon	night
monday	Half Grapefruit **or** Prune Juice Wheat Farina **or** Ready-to-Eat Malt Flake Cereal Soft Cooked Egg Hard Roll	Washington Chowder Corned Beef Hash **or** Roast Leg of Lamb with Gravy (FS) Roast Potato (FS) Buttered Cabbage **or** Fresh Sliced Carrots (FS) Tossed Salad—1000 Island Dressing **or** Orange-Mint Salad Baked Custard (FS) **or** Kadota Figs	Consomme with Rice Half Broiler—Currant Jelly (FS) **or** Liver and Bacon Whipped Potato (FS) Green Beans (FS) **or** Stewed Tomato Watercress Salad **or** Apricot and Nut Salad Cream Puff **or** Coffee Ice Cream (FS)
tuesday	Applesauce **or** Orange Juice Oatmeal **or** High Protein Cereal Grilled Ham Raisin Toast	Split Pea Soup Deviled Eggs with Spanish Sauce **or** Boiled Brisket of Beef (FS)—Horseradish Sauce (F) Parsley Potato Balls (FS) Spinach (FS) **or** Kernel Corn Head Lettuce Salad—French Dressing **or** Green Pepper and Cottage Cheese Salad Lemon Gelatin with Whipped Cream (FS) **or** Pistachio Ice Cream	Pineapple and Lime Juice Cocktail Broiled Fillet of Cod-Lemon Slice **or** Roast Veal with Gravy (FS) Baked Potato (FS) Buttered Beets (FS) **or** Baby Lima Beans Assorted Relishes **or** Pear and Watercress Salad White Cake with Minted Frosting (FS) **or** Green Gage Plums
wednesday	Banana **or** Grapefruit Juice Whole Wheat Cereal **or** Puffed Wheat Cereal Soft Cooked Egg Soft Roll	Cream of Mushroom Soup Salmon Salad Plate **or** Hot Turkey Sandwich with Gravy (FS) Mashed Potato (FS) Buttered Peas (FS) **or** French Fried Eggplant Jellied Cranberry Salad **or** Romaine—Chiffonade Dressing Butterscotch Pudding (FS) **or** Raspberry Sherbet	Apricot Juice Broiled Halibut—Lemon Sauce (FS) **or** Roast Loin of Pork with Gravy Oven Browned Potato (FS) Buttered Cauliflower **or** Asparagus Tips (FS) Orange and Apple Salad **or** Chef Salad—French Dressing Boston Cream Pie (FS) **or** Loganberries in Syrup
thursday	Kadota Figs **or** Orange Juice Farina **or** Ready-to-Eat Malt Flake Cereal Scrambled Egg—Bacon	Corn Chowder Chicken and Spaghetti Casserole (FS) **or** Grilled Bacon Baked Potato Braised Celery **or** Fresh Sliced Carrots (FS) Tossed Salad—French Dressing **or** Peach and Cheese Ball Salad Strawberry Ice Cream **or** Applesauce (FS)	Grape Juice Roast Leg of Lamb with Gravy (FS) **or** Veal Cutlet Creamed Potato (FS) Buttered Wax Beans (FS) **or** Stewed Tomato Watercress Salad **or** Molded Fruit Salad Cherry Cobbler (F) **or** Prune Whip (S)
friday	Orange Halves **or** Apple Juice Wheat Farina **or** Puffed Rice Cereal Poached Egg Hard Roll	Boston Clam Chowder Codfish Cakes—Tomato Sauce **or** Roast Chicken with Gravy (FS) Buttered Rice (FS) Spinach (FS) **or** Mixed Garden Vegetables Cole Slaw **or** Pineapple and Grated Cheese Salad Lemon Cake **or** Fruit Gelatin (FS)	Chilled Blended Juice Broiled Fillet of Flounder—Lemon Slice (FS) **or** Baked Ham with Raisin Sauce Whipped Potato (FS) Baked Acorn Squash (FS) **or** Baby Lima Beans Head Lettuce Salad—French Dressing **or** Tomato Aspic Salad Vanilla Ice Cream with Chocolate Mint Sauce (FS) **or** Purple Plums in Syrup
saturday	Stewed Apricots **or** Orange Juice Oatmeal **or** High Protein Cereal Scrambled Egg	Vegetable Soup Scrambled Eggs with Dried Beef **or** Roast Leg of Veal with Gravy (FS) Baked Potato (FS) Asparagus Tips (FS) **or** Kernel Corn Pear and Cranberry Salad **or** Club Salad Bowl—French Dressing Caramel Sundae (FS) **or** Bing Cherries in Syrup	Consomme with Noodles Swiss Steak with Gravy **or** Broiled Lamb Pattie (FS) Sweet Potato with Apples Buttered Beets (FS) **or** Green Beans Head Lettuce Salad—French Dressing **or** Stuffed Pepper Salad Peach Pie (F) **or** Floating Island (S)
sunday	Half Grapefruit **or** Prune Juice Farina **or** Cornflakes Grilled Bacon Kuchen Bread	Cream of Vegetable Soup Fried Chicken with Gravy **or** Minute Steak (FS) Mashed Potato (FS) Buttered Wax Beans (FS) **or** Cauliflower Romaine Salad—Russian Dressing **or** Mixed Fruit Salad Neopolitan Ice Cream (FS) **or** Apricot Halves in Syrup	Consomme with Rice Egg a la Goldenrod on Toast (FS) **or** Ham Loaf with Broiled Pineapple Oven Browned Potato Grilled Tomato **or** Buttered Peas (FS) Tossed Salad—French Dressing **or** Banana and Nut Salad Chocolate Chip Cookies **or** Tapioca Pudding—Cherry Sauce (FS)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Fresh	U. S. Choice	30 lbs.	
Chipped Beef, Dried	U. S. Good	8 lbs.	
Liver	Steer, sliced	5 lbs.	20
Roast, Sirloin (B.R.T.)	U. S. Choice	10 lbs.	
Steaks, Minute	U. S. Choice, 4 oz. each	20 lbs.	80
Steak, Swiss	U. S. Good, 4 oz. each	5 lbs.	20
LAMB			
Ground, Shoulder	U. S. Good	15 lbs.	60
Leg (B.R.T.)	U. S. Choice, yearling	50 lbs.	
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Ham (Pullman)	Ready-to-eat	30 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	7 lbs.	
VEAL			
Cutlets	U. S. Good, 4 oz. each	5 lbs.	20
Leg (B.R.T.)	U. S. Good	50 lbs.	
FISH			
Cod	Fillets, Canadian	5 lbs.	20
Flounder	Fillets, 4 oz. each	15 lbs.	60
Halibut	Steaks, 5 oz. each	20 lbs.	

Item, Specifications, Amounts & No. of Servings		
POULTRY		
Fowl (Eviscerated)	Grade A, 5 lb. av.	75 lbs.
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.
Fryers (Eviscerated)	Grade A, 2½ lb. av.	115 lbs.
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	40 lbs.
Cranberries	1 lb. bag	5 lbs.
Grapefruit	Seedless, 70s	1 box
Lemons		1 doz.
Oranges	176s	1 box
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	3 stalks
Celery	White	6 stalks
Cucumbers		1 doz.
Eggplant		2 only
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	50 lbs.
Onions, Green	Bunch	1 doz.
Parsley	Bunch	1 doz.
Peppers, Green		2½ doz.
Potatoes, Sweet	Hamper	50 lbs

Item, Specifications, Amounts & No. of Servings			
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine		1 doz. heads	
Squash, Acorn		30 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Watercress	Bunch	2 doz. bunches	
FROZEN FRUITS			
Apricots	Halves, 8 lb. can, 5-1 sugar	8 lbs.	
Cherries	5-1 sugar, pitted, 8 lb. can	24 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Peaches	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
Plums	8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	25 lbs.	150
Beans, Green	Cuts, 2½ lb. pkg.	12½ lbs.	75
Beans, Lima	Small, green, 2½ lb. pkg.	5 lbs.	30
Beans, Wax	Cuts, 2½ lb. pkg.	25 lbs.	150
Cauliflower	Buds, 2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	25 lbs.	150
Spinach	Chopped, 2½ lb. pkg.	30 lbs.	180
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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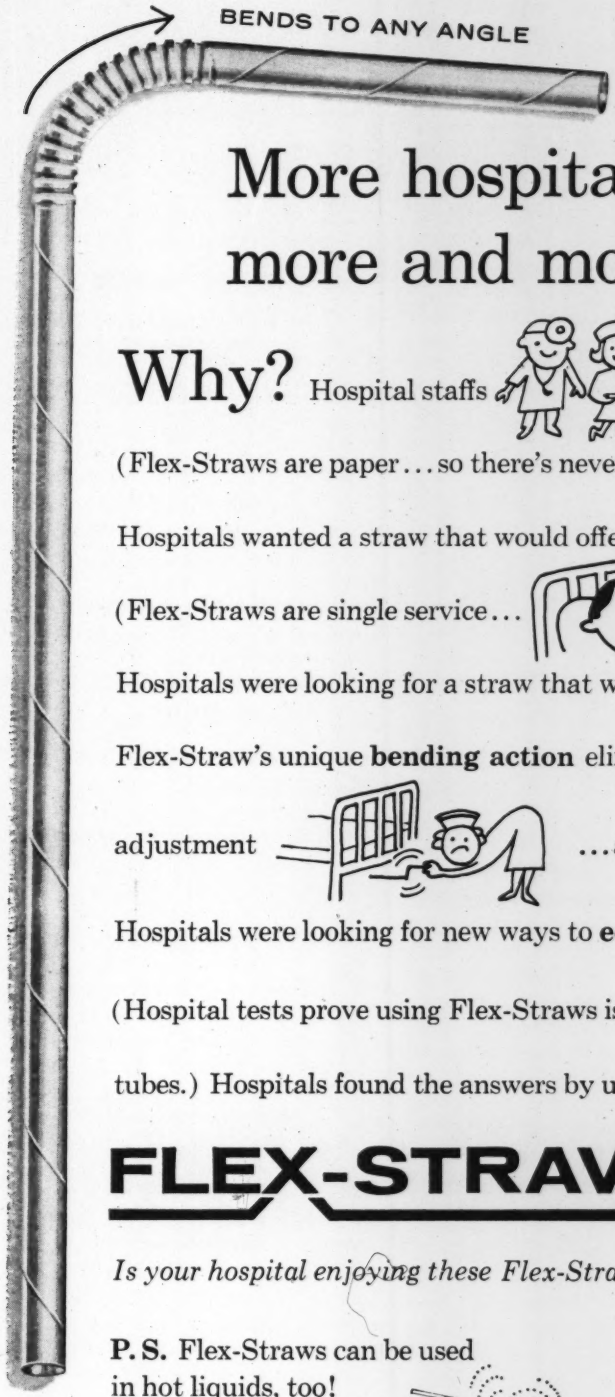

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book reviews

Ethics of radiology

also:
social service project
care of the surgical child

PRINCIPLES OF ETHICAL RADIOLOGICAL PRACTICE. American College of Radiology. Chicago, 1958. 16 pp. 25 cents.

The opening paragraph of this booklet states that "The Principles of Medical Ethics . . . of the American Medical Association and the *Principles of Ethical Radiological Practice* . . . shall be the Principles of Ethics of The American College of Radiology . . . "

The 10 principles of ethical radiological practice deal primarily with professional relationships between radiologists, patients and physicians, although financial relationships between radiologists and hospitals covering billing methods are also included. Illustration and amplification of the principles includes suggestions to radiologists for methods of billing and of accepting or changing hospital staff appointments, two matters of interest to hospital administrators.

Apart from these principles, there is also a policy statement in the form of resolutions for the American College of Radiology adopted by the board of chancellors at its 1958 midwinter meeting, which "represents the considered opinion of the Chancellors, speaking for the College, in regard to the corporate practice of medicine."

The first resolution of the board of chancellors is "*Resolved:* That the policy of The American College of Radiology shall be that it is unethical for any radiologist to enter into a relationship with any hospital, corporation or lay body by whatever name called or however organized which enables it to offer his professional services for a fee . . . "

No comments or explanation are given to this policy statement. The confusion of combining ethics of medical practice and financial relationship between radiologists and hospitals is again introduced in this new resolution. Without further clarification, these resolutions will raise questions on the part of both radiologists and administrators that will need more amplification than the present booklet presents.—ALBERT W. SNOKE, M.D., *director, Grace-New Haven Community Hospital, New Haven, Conn.*

Social service project

OUT-PATIENT SOCIAL SERVICE; A DEMONSTRATION AND STUDY OF FULL-TIME SOCIAL WORK IN ARTHRITIS CLINICS. Jeanette A. Margolies. New York, Arthritis and Rheumatism Foundation, 1958. 34 pp. $1.

This book illustrates how adequate social service augments and improves existing services for arthritis patients.

The report covers an 18-month study by two experienced medical social workers, one in a municipal and the other in a voluntary hospital arthritis clinic. The multiple problems—physical, psychological, social and economic—arising from long-term chronic illness are documented for more than 200 patients. Most of these patients needed and received social service. It is significant that regardless of their medical improvement, patients were better able to cope with their problems at the end of the project.

The New York State Chapter of the Arthritis and Rheumatism Foundation sponsored the social service project, which was motivated by a study on the effect of arthritis on life adjustment. A summary of the latter study is included.

Although budget and shortage of qualified workers would discourage many institutions from providing social service exclusively for arthritis patients, this book can help clinic physicians and personnel to make the most of the service available. The material is of interest to all who serve arthritis patients and may aid the working relationship between doctor and social worker.

The projects reported exemplify the beneficial specialized services of the national health agencies.—VERNON K. BROWN, *director of public information, Passavant Memorial Hospital, Chicago.*

Care of the surgical child

NONOPERATIVE ASPECTS OF PEDIATRIC SURGERY, Report of the 27th Ross Pediatric Research Conference. Columbus, Ohio, Ross Laboratories, 1958. 96 pp. (No charge for professional personnel.)

This is a symposium of excellent papers on a number of current and pertinent phases of the nonoperative problems of pediatric surgery. Although it is not very technical in a medical or surgical sense, it should have distinct appeal to anyone with interest in pediatric surgery and should be of special interest to pediatricians and anesthesiologists.

Hospital administration will be particularly interested in the explanations as to how and why pediatric surgery is different from adult surgery. Recommendations for handling the surgical child recognize that a high degree of understanding and performance by many of the nonmedical departments is needed. Preparing a child for surgery and dealing with his emotional reactions to it begin with the doctors, but can be advanced (or undone) by any or all of the hospital employees who have contact with the patient or his parents.

Other sections of the brochure of particular interest to administrators are those dealing with play problems for surgical patients and the control of nosocomial infections. Distinctions are drawn between children in different age groups.

Statistics given are not overpowering, and some of the conclusions reached are administratively significant for hospitals planning pediatric surgical programs. The report should prove a good resource for review and reference.—HUGO V. HULLERMAN, M.D., *executive vice president, The Children's Hospital of Michigan, Detroit.*

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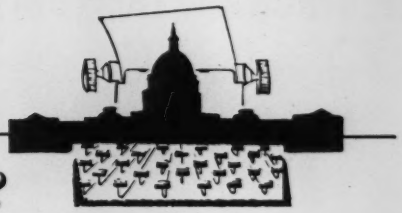

More Federal Funds for Health?

Most intriguing and only direct reference to health programs in the President's State of the Union message was the sentence: "Next year we will be spending an increased amount on health programs." He failed to explain what health programs the administration had in mind for increased expenditures.

In the past, President Eisenhower has sent Congress special messages on new health and medical projects after his budget address. The absence of specific references to areas of increased federal spending for health programs has led most observers of the capital scene to assume the proposed $77 billion budget will not reflect a substantial increase in funds for new federal medical programs.

Health, Education, and Welfare Secretary Arthur S. Flemming's influence was seen in the President's speech when he told Congress of plans to establish a nongovernmental committee which would study and report on long-range national goals for every segment of the economy. The President said this "summit-level" planning committee would concern itself with the nation's health objectives as well as "methods to meet such goals and what levels of government —local, state, or federal—might or should be particularly concerned." This is a proposal Secretary Flemming advanced all fall in press conferences as well as before dozens of voluntary groups in meetings called to advise HEW on its existing and proposed programs.

TAXES AND THE STATE OF THE UNION

Hospitals will be vitally interested in a little-publicized development announced by Rep. Wilbur Mills (D-Ark.), chairman of the House Ways and Means Committee.

Chairman Mills has announced that the main task of his committee in the 86th Congress will be to revise and simplify the federal tax system. He said he did not believe there could be a tax cut this year.

Within the broad framework of tax policy, the Mills committee will look into exemptions now granted a whole range of nonprofit organizations, including hospitals. Some congressmen feel that exemptions granted to certain nonprofit groups should be restudied, with an eye toward finding additional sources of federal revenue.

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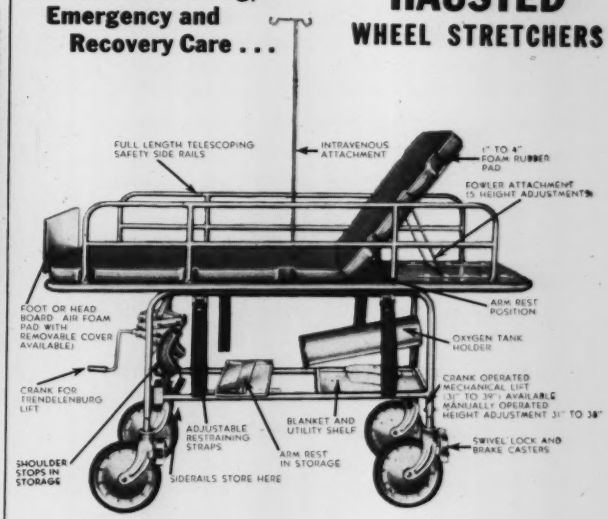
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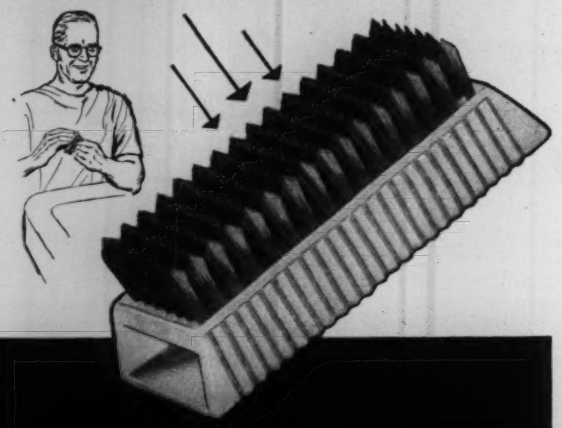

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Mills tax study in his State of the Union message. He announced that the Treasury Department would undertake revision of the entire tax structure. He called for the tax study "to remove inequities and to enhance incentives for all Americans to work, to save and to invest." He recommended early action on his tax study proposal as quickly as "our fiscal condition permits."

200 Health Bills Introduced

More than 2000 new bills were introduced during the first day of Congress. More than 200 of them were concerned with some aspect of federal medical programs, Of these, the vast majority will probably never be heard of again. The following bills, some of which may receive committee hearing, are of interest to hospitals:

HR 10 (sponsored by Rep. Eugene J. Keogh, [D-N.Y.]): to encourage voluntary pension plans for self-employed individuals. HR 97, introduced by Rep. John Fogarty (D-R.I.), and several other bills had this same title.

HR 85 (Rep. Frank M. Coffin [D-Maine]) to amend Title VI of the Public Health Service Act to encourage construction of diagnostic and treatment centers in rural areas.

HR 143 (Rep. Keogh) to make gifts to nonprofit voluntary health insurance plans tax deductible.

HR 167 (Rep. J. E. Kilgore [D-Tex.]) to encourage extension and improvement of voluntary health prepayment plans or policies.

HR 208 (Rep. James H. Morrison [D-La.]) to provide for federal contributions and payroll deductions towards personal health service benefits for federal civilian employees and dependents. This bill was drafted by the AFL-CIO unions of federal employees.

HR 178 (Rep. Thomas J. Lane [D-Mass.]) to authorize payroll deductions and federal contributions for federal employees health insurance.

HR 185 (Rep. Lane) to amend Titles I, IV, X, and XIV of the social security act so as to further assist the states in extending aid for medical care to persons eligible for public assistance under such titles.

HR 188 (Rep. Lane) to establish a minimum wage of $1.25 an hour. A number of other bills to set this figure were also introduced.

Forand Medical Care Bill

Rep. Aime J. Forand (D-R.I.) told Washington reporters he thinks his bill to provide hospital and medical benefits for aged persons receiving social security payments (introduced in Congress last year, but not passed) has a greatly improved chance of passage by Congress in 1959, despite attacks on it as "socialized medicine."

He based his prediction on larger Democratic majorities in Congress, steadily stronger support throughout the country for the concepts embodied in the bill, and indications that it has "stirred up the American Medical Association." Rep. Forand is the second-ranking Democrat on the House Ways and Means Committee which will handle the legislation. He plans to reintroduce his bill this month; it will be basically the same as the one he submitted last year for committee study, he said, but would contain some "refinements." Rep. Forand reported that his office has been "flooded" by mail in recent weeks indicating public support is greater for his bill now than it was a year ago.

U.S. Employees Health Insurance

One major health bill destined for early hearings is a comprehensive federal employee health program offered by Rep. James Morrison (D-La.). The Morrison bill has strong AFL-CIO support and would insure federal employees (active and retired) and their dependents against hospital, surgical, medical, and related costs. The measure is to be the first major piece of federal employee legislation to be considered by the Senate, where it will be sponsored by Chairman Olin D. Johnson (D-S.C.). Main features of the proposed federal employee health program are:

(1) Eligibility for all government employees and immediate members of their families on a voluntary basis.

(2) Estimated cost to the government of between $250 million and $300 million a year.

(3) Wide choice of plans or companies for employees for basic insurance with some restrictions. Also a choice between indemnity-type plan or service plan.

(4) Major or so-called catastrophic insurance to be provided free of charge by the government. In order to obtain free catastrophic insurance coverage, employees would be required to participate in the basic health insurance program.

(5) Catastrophic insurance to pay 75 per cent of the cost of medical care after basic insurance runs out. Employees would be required to pay the next $100 to $300, however, depending on their income before catastrophic benefits would begin.

(6) Both basic and catastrophic insurance protection to be available after retirement for employees keeping up premium payments.

Social Security Found Financially Sound

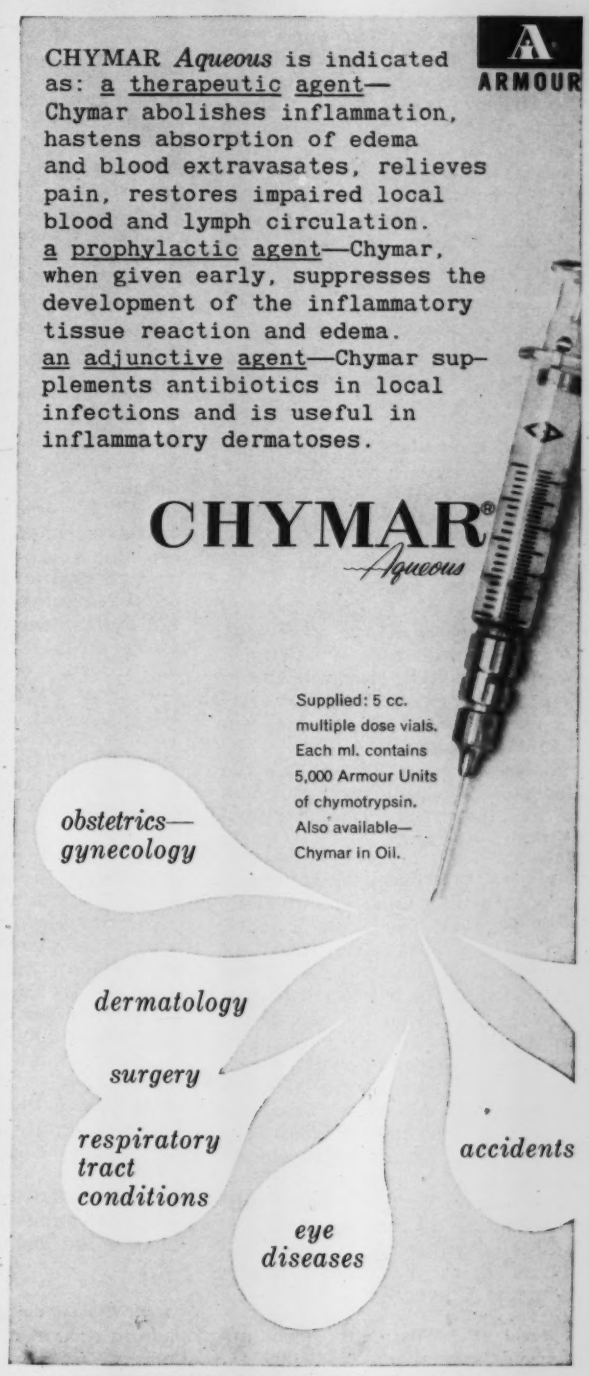
A 12-man federal advisory council of experts representing industry, labor, and other groups has completed a year-long study of social security financing at the request of Congress. The advisory group's findings were that the social security system is financially sound and existing law makes adequate provision for meeting both short and long-range costs. To keep the program on a sound basis, the experts said the social security tax must be gradually raised to 4 per cent a year on both employees and employers by 1966, as now scheduled by law.

Meanwhile, social security taxes took a bigger bite from most American workers on Jan. 1. Taxes were raised from 2.25 per cent on the first $4200 of yearly pay to 2.5 per cent on the first $4800. Contributions by employers were raised by the same amount. Simultaneously, retirement benefits under social security were raised Jan. 1 by an average of 7 per cent.

White House Conference on Aging

The President is expected to ask Congress for an early supplemental appropriation for grants to help the states prepare for the White House Conference on Aging in January 1961.

Under the law which authorized the conference, each state may receive from $5000 to $15,000 in federal grants. The Department of Health, Education, and Welfare has expressed the hope that a congressional appropriation will be made early this winter so that the states may start local conferences and studies on problems of older persons. The amount of federal money each state will receive will depend upon the nature of the studies planned by the state.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● **O. B. Ayers Jr.** has been appointed administrator of Fairmont (W.Va.) General Hospital. He was formerly administrator of Halifax Community Hospital, South Boston, Va. Mr. Ayers succeeds **Cheney Ellerbe,** who resigned to return to school.

Paul N. Bridge has been appointed to succeed Mr. Ayers at Halifax Community Hospital. Mr. Bridge was formerly assistant administrator at Roanoke (Va.) Memorial Hospital. He is a graduate of the Medical College of Virginia program in hospital administration.

● **Francis Fillingim** has been appointed assistant administrator of Burge Hospital, Springfield, Mo. He was formerly chief pharmacist at Deaconess Hospital, St. Louis. Mr. Fillingim is a graduate of the Washington University program in hospital administration.

● **Nestor M. Fowler** has been appointed business administrator of the State Hospital South, Blackfoot, Idaho, succeeding **Eugene Boyd.** Mr. Fowler has been associated with the hospital in various capacities for seven years.

● **John A. Maloney** has been appointed administrator of Lawrence County Hospital, Lawrenceburg, Tenn. He was formerly administrative assistant at Presbyterian Hospital, Knoxville, Tenn. Mr. Maloney is a graduate of the Georgia State College of Business Administration program in hospital administration.

● **Arthur E. Miller** has been appointed director of Salt Lake County General Hospital, Salt Lake City, Utah. He was formerly assistant director of the hospital. Mr. Miller is a graduate of the Northwestern University program in hospital administration.

Vernon L. Harris, formerly director of Salt Lake County General Hospital and administrator of the University of Utah Medical Center Hospital (in planning stage), Salt Lake City, resigned the Salt Lake County post to assume full-time duties at the University of Utah Medical Center Hospital. Mr. Harris holds a master's degree from the University of Idaho.

● **David W. Miller** has been appointed special assistant to the manager of the Veterans Administration Hospital, Albany, N.Y. He was formerly electro-medical equipment representative for the VA area medical office in Boston.

● **Robert F. Peck** has been appointed assistant director of Research Hospital, Kansas City, Mo. He was formerly assistant director of Springfield (Ohio) City Hospital. Mr. Peck is a graduate of the Washington University program in hospital administration.

● **Howard L. Place** has been appointed administrator of Dunlap Memorial Hospital, Orrville, Ohio, succeeding **Dolores Badger.** Mr. Place was formerly assistant administrator of the hospital. Mrs. Badger will continue with the hospital as consultant and assistant administrator.

● **Philip K. Reiman** has been appointed assistant director of Maine Medical Center, Portland. Mr. Reiman occupies the position left vacant by **John C. Barker** when he was appointed director of the center. Mr. Reiman was formerly assistant director of the Graduate Hospital, University of Pennsylvania, Philadelphia. He is a graduate of the University of Chicago program in hospital administration.

MR. REIMAN

● **William E. Reiser Jr.** has been appointed assistant administrator of Riverview Hospital, Red Bank, N.J. He formerly held various business department positions at Jersey City (N.J.) Medical Center. Mr. Reiser is a graduate of the Michigan State University program in hospital administration.

● **Anthony R. Schultz** has been appointed administrator of the Bucklin (Kans.) District Hospital.

● **Thomas Shirtz** has been appointed assistant administrator of the Lutheran Medical Center, Brooklyn, N.Y.

● **J. W. Singleton** has been appointed administrator of Meriwether Memorial Hospital, Warm Springs, Ga. He was formerly administrator of Bacon County Hospital, Alam, Ga. Mr. Singleton is a graduate of the Georgia State College course in hospital administration.

Robert D. Rowe succeeds him as administrator of Bacon County Hospital. Mr. Rowe is a graduate of the Georgia State College course in hospital administration.

● **Ellen L. Stahlnecker** has retired as administrator of Crittenton General Hospital, Detroit. She has been administrator since 1944. **D. Eugene Sibery,** associate administrator of the hospital, has been appointed her successor. **William S. Atkinson** has been appointed assistant to the administrator.

● **Sister Gertrude of Providence** has been appointed administrator of Providence Hospital, Everett, Wash. She was formerly assistant administrator of St. Vincent's Hospital, Portland, Ore. Sister Gertrude is a graduate of the St. Louis University program in hospital administration.

● **Sister M. Francis Xavier Villerot, R.S.M.,** has been appointed administrator of St. Joseph Mercy Hospital, Detroit. She is a graduate of the University of Michigan course in hospital administration.

● **Sister Mary Louis Wenzl** has been appointed administrator of Good Samaritan Hospital, Kearney, Nebr. She was formerly director of nursing at Creighton Memorial St. Joseph Hospital, Omaha, Nebr.

● **Sister Mary Margarite, S.S.M., R.N.,** has been appointed administrator of St. Mary's Infirmary, St. Louis. She was formerly administrator of St. Mary's Ringling Hospital, Baraboo, Wis.

● **Sister Mary Raphael** has been appointed administrator of Okarche (Okla.) Memorial Hospital. She succeeds **Sister Mary Consilia.**

● **Sister M. Roberta** has been appointed administrator of Wichita-St. Joseph Hospital, Wichita, Kans. She was formerly administrator of Pratt (Kans.) County Hospital and succeeds **Sister M. Etheldreda.**

● **George H. Vogt** has been appointed controller, Department of Medical Institutions, Alameda County, Calif. He was formerly assistant administrator of the Uni-

versity of California Medical Center, San Francisco. Mr. Vogt is a graduate of the University of California program in hospital administration.

● **Lawrence Walker** has been appointed administrator of Davis Hospital, Statesville, N.C.

Deaths

● **Arthur Allen** superintendent of Rockaway Beach (N.Y.) Hospital, died on Oct. 17, 1958, at the age of 58. He had been administrator of the hospital for 12 years.

William J. McShane, director of the hospital's Development Department, was named to succeed Mr. Allen.

● **Reverend John Goodridge Martin,** former hospital administrator, died Dec. 31, 1958, in Coral Gables, Fla., at the age of 73. Rev. Martin was administrator of St. Barnabas Hospital, Newark, N.J., from 1923 to 1950. He served as president and executive secretary of the New Jersey Hospital Association and as president of the American Protestant Hospital Association. Rev. Martin also served on American Hospital Association committees and was a member of the joint committee of AHA, APHA, and the Catholic Hospital Association. He is survived by his widow, Lilly Lane Martin; a son, John D. Martin; four sisters, two brothers, and two grandchildren.

● **Mary M. Roberts** died in New York City on Jan. 11 at the age of 82. Miss Roberts was chief nurse of the Army Nurse Corps in World War I, editor of the *American Journal of Nursing* from 1921 to 1949, and editor emeritus of the publication at the time of her death. Among honors bestowed upon Miss Roberts were: Bronze Medal of Ministry of Social Welfare of France; honorary fellow, American College of Hospital Administrators; Army Certificate of Appreciation (highest honor the Army can bestow on a civilian); International Red Cross' Florence Nightingale Medal, and the Mary Adelaide Nutting Award for Leadership in Nursing. She was a life member of the American Hospital Association.

MISS ROBERTS

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An emergency comes up. A doctor is urgently needed . . . *now!* But he's "somewhere in the building" . . . no one knows exactly where. With Motorola Radio Paging, you can contact him in seconds. Here's how. The switchboard operator sounds a tone in his Radio Pager . . . (and in his only). He is alerted instantly, just as if she reached out and tapped him on the shoulder. He presses the button on his Pager and hears the full voice message. Total time elapsed . . . just seconds, and the emergency is being handled.

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IN A RECENT QUESTIONNAIRE:

335 OUT OF 350 REPORTING DOCTORS SAID THEY RECOMMENDED SUPP-HOSE TO THEIR PATIENTS!

Recently we wrote to approximately 1100 doctors. We enclosed a letter, questionnaire and an offer of a sample pair of Supp-hose. Of the 350 doctors responding, 335 of them indicated they were recommending Supp-hose to their patients. This is just one phase of the growing popularity of Supp-hose. From every part of the country comes news of more and more women who find that Supp-hose gives them the fashionable look they want . . . and at the same time eases tired legs!

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As you know, expectant mothers, housewives, and working women all complain about discomfort of the extremities. Where heavy surgical stockings are not prescribed, Supp-hose is excellent for gentle support all day long. And remember: Supp-hose contains no rubber. Every stitch is fine nylon with a special twist that provides an elastic quality.

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IN CALIFORNIA, NEW YORK—

Hospital Groups Prepare Disaster Plans

The California Hospital Association, after a two year study, has published a disaster plan outline which, in the words of CHA executive director Avery M. Millard, "is directed primarily to assist hospitals to prepare for expanding facilities for receipt of casualties."

During a disaster situation, the California plan states, the person in charge of the hospital, having received a call for assistance, should determine the following facts: "the nature of the disaster; an estimate of the number and type of patients who will be received; an estimate of the time of arrival."

The California plan then calls for a recheck from the source reporting the disaster. "You should phone or contact the source again and verify the information since initially it will be given and received under emotional pressure," the plan states. It was suggested that the hospital might have to send a survey team to the scene of the disaster, in order to prepare for the situation as it develops.

Under the plan devised in California, after the source reporting the disaster has been rechecked, the work force is to be alerted. A two-page appendix to the plan briefly outlines such points as: means of calling the alert; code signal; person calling the alert; alerting the employees and volunteers not in the hospital; internal traffic and panic control and external guard system, and means of calling off the alert.

As the disaster plan is put into effect, the California plan states, one or more control centers should be established in the hospital. It was suggested that the administrator's office "is not always the best place for all these activities to converge, and it is advisable that the control center activities be placed in the most advantageous locations."

It was also suggested that the person in charge of the hospital "leave someone in the control center to receive messages and who could contact you immediately; then check the various sections to see that they are working according to plan and assist them in any problems they may face."

This is how the various hospital departments would function under disaster conditions, according to the California plan:

Personnel: alert doctors, nurses, other hospital personnel, and volunteers.

Engineering and housekeeping: set up equipment and assist nurses in concentrating inhouse patients in one area or evacuating them.

Equipment and supply: secure equipment and supplies for pharmacy, nursing care, dietary, and other activities. In preparing for a disaster (before the disaster situation arises), it was suggested that the individual hospital meet with its normal suppliers and discuss procurement and delivery in an emergency. The supplier should have an "emergency supply unit" on hand (containing material ranging from abdominal pads, to plaster bandages and syringes—all in predetermined sizes and quantities) which would be shipped to the hospital on consignment as soon as the supplier is notified by the hospital. The supplier would then assemble another unit for standby purposes. Emergency drug supplies would come from doctors and drugstores.

Nursing department: set up receiving and sorting areas, patient care areas, operating rooms, central supplies, and the various activities which are usually handled by this department.

Laboratory and x-ray: increase operating potential to cope with the influx of patients.

It was also suggested that hospitals contact local health, medical, and civil defense authorities so that additional assistance may be given to the hospital. ■

"Hospital members of Erie County, N.Y., (Buffalo) have agreed to accept and utilize the County Hospital Disaster Plan for incidents in Erie County," the Western New York Hospital Council has reported. The plan was devised, stated Wilson Wells, executive director of the council, "to circumvent the problem of various agencies doing disaster planning with various results."

Under the western New York plan, a hospital, having been notified of a disaster, would notify either the city or county police and "ask for investigation and verification of need for hospital/medical assistance."

According to the New York plan the first ambulance intern/resident to arrive at the scene of the disaster:

1. Assumes medical charge
2. Notifies police dispatcher via radio
   a. Number injured
   b. Type of injuries (burns, fractures, etc.)
   c. Transportation needs
   d. Hospitals needed (use those closest to scene)
   e. Medical assistance needed at scene (if any)
3. Remains at scene
   a. Dispatches ambulances
   b. Directs and administers first aid
4. Returns to hospital
   a. When all injured have been removed, or
   b. When relieved of charge by county health officer, a member of his staff, or by county medical examiner.

Within the framework of this plan, police dispatchers are to send a police car and ambulance "to investigate and verify all disaster catastrophe calls, relay hospital medical information from physician in charge at scene to hospitals, alert hospitals according to location of incident and number and type of injured."

The individual hospital involved in caring for disaster victims would then utilize as much of its own disaster plan as it needed "in accordance with estimate of physician in charge at scene." ■

FOLLOWING CHICAGO SCHOOL FIRE—

Ideas Exchanged to Improve Disaster Care

Administrators of the four Chicago hospitals which provided care for victims of the Our Lady of the Angels School fire, last December (**HOSPITALS**, J.A.H.A., Dec. 16, 1958), shared their experiences with members of the Chicago Hospital Council at a recent symposium sponsored by that group.

The four administrators, who served as panelists, were: P. A. DeMoon, administrator, Franklin Boulevard Community Hospital; J. R. Garwin, administrator, Garfield Park Community Hospital; William R. Sittler, administrator, Walther Memorial Hospital; Sister M. Almunda, administrator, St. Anne's Hospital.

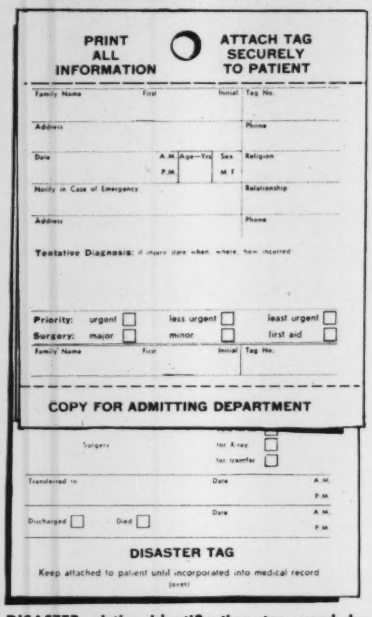
Hospitals should be notified by the police or fire departments when a disaster occurs, the panelists agreed. They said that if the emergency had been reported promptly to the hospitals, the institutions would have had more "lead" time in which to alert personnel.

Some hospitals, it was reported by administrators attending the meeting, were notified about the disaster, but did not receive any patients. None of the hospitals that received patients were alerted.

BUSY SWITCHBOARDS

Each of the four hospitals which accepted the school disaster victims reported that its switchboard was soon flooded with telephone calls. It was suggested that every hospital have available for emergency use a pay telephone or a telephone not tied in with the regular hospital telephones.

Other suggestions were that the telephone company's mobile telephone equipment should be utilized in an emergency and that the phone company have a special information number which families could call during a disaster to get news of their loved ones.


PRINT ALL INFORMATION

ATTACH TAG SECURELY TO PATIENT

Family Name | First | Initial | Tag No.

Address | Phone

Date | A.M. P.M. | Age—Yrs. | Sex M F | Religion

Notify in Case of Emergency | Relationship

Address | Phone

Tentative Diagnosis: (if injury state when, where, how incurred)

Priority: urgent ☐ less urgent ☐ least urgent ☐

Surgery: major ☐ minor ☐ first aid ☐

Family Name | First | Initial | Tag No.

COPY FOR ADMITTING DEPARTMENT

Surgery | for X-ray ☐ for transfer ☐

Transferred to | Date | A.M. P.M.

Discharged ☐ Died ☐ | Date | A.M. P.M.

DISASTER TAG

Keep attached to patient until incorporated into medical record (over)

DISASTER victim identification tag used by Franklin Boulevard Hospital, Chicago.

The panel members agreed that prepackaged and presterilized injectables and dressings were an important aid during the emergency period because the need for sterilization was eliminated, quantity and quality were standard, and nurses were familiar with the standard packaging used.

It was found that volunteers not familiar with the hospital or its disaster plan were of little help during the emergency.

Three-part identification tags were used at Franklin Boulevard Hospital. The parts of the tag were interleaved with carbon paper and a string was attached so that it could be tied to a patient.

TAGS' PRO AND CON

Although the tag provided a quick means of identification and could be attached easily to the patient, the disadvantages of the tag were that it was too small, the type was not large enough, the tags were not numbered ahead of time, and all parts of the tag were not the same size.

It was suggested by some that school-age children be required to wear metal identification tags. It was pointed out that it would be difficult to make children wear these tags at all times and that disasters do not necessarily involve children.

There was general agreement that providing care for the victims of a disaster "is merely an extension of the emergency services of a hospital" and that hospitals must keep sufficient supplies on hand to meet emergencies.

No definite suggestions were made as to how to control road and sidewalk traffic around the hospitals, although the area was clogged with cars and pedestrians for blocks around after the disaster. ■

REPORT ON CONDITIONS IN NEW YORK—

Most Hospitals Bar Alcoholic Patients

Only 35 per cent of the public general hospitals in New York State would admit patients with a primary diagnosis of alcoholism, as would 20 per cent of the voluntary general hospitals, and 9 per cent of the proprietary general hospitals.

These statistics are from a report by the New York State Interdepartmental Health Resources Board and the Hospital Association of New York State. The report was published in the Jan. 15 issue of the *New York State Journal of Medicine*.

The study was designed to determine the extent to which alcoholic patients are now admitted to general hospitals in the state, the experience of the hospitals doing so, and the reasons why other hospitals reject such patients.

In the Rochester region, in western New York, approximately 58 per cent of the general hospitals admitted patients with alcoholism. However, only 10 per cent of hospitals in New York City and the immediate metropolitan area admitted patients for alcoholism.

AGAINST REGULATIONS

Approximately 75 per cent of the public hospitals and 45 per cent of the voluntary hospitals which do not admit alcoholics stated that their regulations preclude their acceptance of alcoholic patients.

Other reasons given for rejecting alcoholic patients were: difficulty in managing them; lack of facilities; lack of personnel, and availability of other facilities in the community.

Of the hospitals admitting alcoholic patients, 40 per cent indicated that these patients were not usually troublesome and almost all hospitals stated that the tranquilizing drugs were helpful in quieting disturbed alcoholic patients and making them manageable.

Almost 92 per cent of alcoholic patients discharged from voluntary general hospitals paid their hospital bills in full or in part. Almost 48 per cent of those discharged

from public general hospitals paid their hospital bills in full or in part.

Approximately 24 per cent of hospitals admitting alcoholic patients indicated that they made no provision for care of alcoholic patients after hospitalization. Almost 62 per cent referred patients to a private physician. Twenty-nine per cent of the hospitals accepting alcoholic patients referred these patients to other outpatient services, following hospitalization. Approximately 44 per cent of the hospitals referred patients to Alcoholics Anonymous. Hospitals often made several referrals for individual patients, the report showed.

Authors of the report were: Dr. I. Jay Brightman, executive director of the Interdepartmental Health Resources Board; Charles M. Royle, executive director of the hospital association, and their coworkers—Bernard Ferber, Paul F. Robinson, and William T. Robinson.

ALCOHOLICS NEED HOSPITALS

The report noted that the American Hospital Association and the American Medical Association had recently emphasized that the alcoholic patient needs the resources of the community general hospital and urged hospitals to accept such patients.

Admission of alcoholic patients by additional hospitals was recommended by the authors, based on the results of their study. "Our own interpretation is that, while the present situation regarding admission of alcoholic patients in general hospitals leaves a great deal to be desired, there is much in these findings upon which we can base an educational program directed at improving the situation and which gives us hope for the future."

The authors also noted that several hospitals accepted alcoholic patients who were sober at the time of admission, but were in need of medical treatment and observation. This showed, the authors stated, a "willing acceptance of alcoholism as a disease rather than as a periodic bout with acute intoxication." ■

Hospital Association Lists Another 18 Life Members

Eighteen persons who have been members of the American Hospital Association for 30 years have been added to the Association's roster of life members. Life members are not required to pay AHA dues.

The new life members are, as announced by Dr. Edwin L. Crosby, AHA director:

Dr. Francis J. Bean, administrator, Pima County General Hospital, Tucson, Ariz.

Dr. Frank R. Bradley, director, Barnes Hospital, St. Louis.

George R. Burt, superintendent, Piedmont Hospital, Atlanta.

E. M. Collier, administrator, Hendrick Memorial Hospital, Abilene, Tex.

Dr. Allan Craig, consultant in hospital planning and organization, New York City.

Charles H. Dabbs, board member, Benedict Memorial Hospital, Ballston Spa, N.Y.

Max DeKaye, superintendent, Beth-El Hospital, Brooklyn, N.Y.

Mary E. Geiser, former administrator, Mary Free Bed Guild Children's Hospital and Orthopedic Clinic, Grand Rapids, Mich., (retired and living in Nunda, N.Y.).

Harold A. Grimm, superintendent, Millard Fillmore Hospital, Buffalo, N.Y.

R. L. Loy, administrator, Mercy Hospital-Oklahoma City (Okla.) General Hospital.

William S. McNary, executive vice president, Michigan Hospital Service, Detroit.

Bertha W. Mears, hospital administration consultant, Georgia Department of Public Health, Atlanta.

Elizabeth R. Nanes, R.N., administrator, Adelphia Hospital, Brooklyn, N.Y.

Harold T. Prentzel, administrator, Montgomery Hospital, Norristown, Pa.

Abraham Rosenberg, administrator, Hospital for Joint Diseases, New York City.

Martha R. Speer, R.N., superintendent, Columbia Hospital, Wilkinsburg, Pa.

Moir P. Tanner, director, Children's Hospital of Buffalo (N.Y.).

Jewell White Thrasher, R.N., administrator, Frasier-Ellis Hospital, Dothan, Ala. ■

Blue Cross Payments Exceed $1 Billion in Nine Months

An all-time Blue Cross record for hospitalization expenditures was set by the 83 Blue Cross Plans during the first nine months of 1958; more than $1 billion of total Plan income was expended in hospitalization benefits for Plan members.

During the nine month period, Plans in the United States expended $959,051,334, or 97.66 per cent of income, on hospital care. Canadian Plans spent $61,637,043, or 94.81 per cent of their income, for care in hospitals.

Operating expenses for the Plans, the Blue Cross Commission reported, reached a new low; 5.86 per cent of total income was expended for this purpose. For the first nine months of 1958, operating costs for U. S. Plans represented 5.93 per cent of their total income, compared with 6.01 per cent for the first nine months of 1957. Operating costs during the first nine months of 1958 for Plans operating in Canada represented 4.78 per cent of total income, compared with 5.33 per cent during the same period of the previous year. ■

CURRENT LISTINGS OF NEW ASSOCIATION MEMBERS

NEW INSTITUTIONAL MEMBERS

CALIFORNIA

Sierra Nevada Memorial Hospital, Grass Valley.

DISTRICT OF COLUMBIA

Bureau of Health and Hospitals, National Catholic Welfare Conference, Washington.

ILLINOIS

Tinley Park State Hospital, Tinley Park.
McKinley Memorial Hospital, Urbana.

LOUISIANA

Natchitoches Parish Hospital Service District, Natchitoches.

MASSACHUSETTS

Lakeville State Sanatorium, Lakeville.
Pondville Hospital, Norfolk.
North Reading State Sanatorium, North Reading.
Rutland State Sanatorium, Rutland.
Tewksbury Hospital, Tewksbury.

MISSISSIPPI

Jefferson Davis Memorial Hospital, Natchez.

NEW YORK

Ransomville General Hospital, Ransomville.
Community Hospital of Greater Syracuse, Syracuse.

OHIO

Cambridge State Hospital, Cambridge.
Rollman Receiving Hospital and State Institute of Psychiatry, Cincinnati.
Columbus State School, Columbus.
Gallipolis State Institute, Gallipolis.
Lima State Hospital, Lima.
Orient State Institute, Orient.
Toledo State and Receiving Hospitals, Toledo.

WASHINGTON

Skagit Valley Hospital, Mt. Vernon.

CANADA

Portage Hospital District Number 18, Portage La Prairie, Manitoba.

NEW PERSONAL MEMBERS

Bisson, Frank G.—adm.—Ludlow (Mass.) Hospital Society.
Carr, Joseph F.—credit mgr.—Palo Alto-Stanford Hospital Center, Palo Alto, Calif.
Damberg, David V.—adm. asst.—Rhode Island Hospital—Providence.
Dauterive, Dr. E. Weeks—asst. dir.—Dauterive Hospital—New Iberia, La.
Fronizer, Peter M.—student—Northwestern University—Chicago.
Garrett, John L.—student in hosp. adm.—State University of Iowa—Iowa City.
Khouri, Yvonne G.—student—Northwestern University—Chicago.
Letts, Glenor M., R.N.—student in inst. adm.—Michigan State University—East Lansing.
Lubbers, Gilbert R.—student in hosp. adm.—State University of Iowa—Iowa City.
Monedero, Carlos C.—student in hosp. adm.—Northwestern University—Chicago.

NSUBRAND, CAPT. WILLIAM G.—USAF, MSC—Army Medical Service School—Fort Sam Houston, Tex.
OPHEIM, DENNIS—student—State University of Iowa—Iowa City.
PEABODY, JEAN—asst. for med. purch.—Stanford (Calif.) University.
ROSE, MYRON—student in hosp. adm.—Northwestern University—Chicago.
ROSSMAN, DR. ABRAHAM—hosp. adm. student—Columbia University—New York City.
WALKER, HOWARD A., JR.—student in hosp. adm.—State University of Iowa—Iowa City.
WIRTH, HENRY E.—hosp. engr.—4050th USAF Hospital—Westover, Mass.
YARBROUGH, IMOGENE—exec. dir. and educ. supv.—Louisiana State Board of Nurse Examiners—New Orleans.

HOSPITAL AUXILIARIES

Women's Auxiliary of El Centro (Calif.) Community Hospital.
St. Francis Hospital Guild—Lynwood, Calif.
San Rafael (Calif.) General Hospital Auxiliary.
Women's Auxiliary of Goddard Memorial Hospital—Stoughton, Mass.
St. Ann's Hospital Auxiliary—Anaconda, Mont.
Auxiliary of All Souls Hospital—Morristown, N.J.
Auxiliary of De Leon (Tex.) Municipal Hospital.

Opinions and ideas

(Continued from page 23)

to use nursing unit clerks and nurses aids.

The first effort in this country to do time and motion studies, and hence to efficiently organize and administer nursing departments was done in Bellevue Hospital, New York City, by Blanche Pfefferkorn (then director of studies, National League for Nursing Education) and Marion Rottman, director of nursing services, City of New York Hospital, in, I believe, 1927 or 1928. When I went from Manning Paper Mills to the Albany Hospital in about 1932, I heard of this study and went to New York to talk to the ladies. This resulted in our hiring one of the two nurses who had been trained in and had done the time and motion studies at Bellevue.

Incidentally, back in the 1930 depression days, R.N.'s were a dime a dozen. They would work for room, board, laundry and $15 or $20 a month.

In 1932 we were paying $90 per month. We took $40 of this out for maintenance whether or not the nurse lived "in." This always bothered me.

By 1936, when our studies and resulting changes in physical layout, nursing procedures, and staffing patterns had produced substantial savings, we gave part of the savings back to nursing department employees. R.N. salaries were upped to $110 per month, all paid in cash. Nurses could buy back from us as little or as much maintenance as they wanted.

By 1939-40-41, when nurses were getting scarce, our policies resulted in all the R.N.'s we needed.—EVERETT W. JONES, *hospital consultant, Fort Myers Beach, Fla.*

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For details, write: American Hospital Association, Huntington Laboratories Educational Fund, 840 North Lake Shore Drive, Chicago 11, Illinois. Deadline for applications is February 9, 1959. Huntington Laboratories has no part in the selection of winners.

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Hospital association meetings

(Continued from page 6)

4-8 **Dietary Department Administration,** Pittsburgh (Pick-Roosevelt Hotel)
6-8 ***American Pediatric Society,*** Buck Hill Falls, Pa.
7-8 Tennessee Hospital Association, Nashville (Andrew Jackson Hotel)
11-13 Canadian Hospital Association, Montreal (Queen Elizabeth Hotel)
11-14 Texas Hospital Association, Houston (Shamrock-Hilton Hotel)
11-15 ***National League for Nursing,*** Philadelphia (Convention Hall)
13-15 Upper Midwest Hospital Conference, St. Paul (St. Paul Auditorium; Lowry and St. Paul Hotels)
14 Massachusetts Hospital Association, Boston (Statler Hotel)
18-21 **Hospital Dental Service,** San Francisco (Sheraton-Palace Hotel)
20-22 Middle Atlantic Hospital Assembly, Atlantic City (Convention Hall)
20-22 New Jersey Hospital Association, Atlantic City (Convention Hall)
20-22 Hospital Association of New York State, Atlantic City, N. J. (Convention Hall)
20-22 Hospital Association of Pennsylvania, Atlantic City, N. J. (Convention Hall)
24-29 ***National Tuberculosis Association,*** Chicago (Palmer House)
25-27 **Hospital Law,** Boston (Somerset Hotel)
25-29 **Nursing Service Administration,** Cleveland (Pick Carter Hotel)
30-June 4 Catholic Hospital Association, St. Louis (Kiel Auditorium)

JUNE

1-3 ***American National Red Cross,*** Atlantic City, N. J.
1-3 **Advanced Institute for Medical Record Librarians,** Chicago (AHA Headquarters)
1-6 ***International Hospital Congress,*** Edinburgh, Scotland
2-3 Maine Hospital Association, Rockland (Samoset Hotel)
4-5 ***American Geriatrics Society,*** Atlantic City, N. J.
8-10 **Administrators' Secretaries,** Chicago (AHA Headquarters)
8-12 ***American Medical Association,*** Atlantic City, N. J., (Convention Hall)
10 Connecticut Hospital Association
10-12 North Carolina Hospital Association, Blowing Rock (Mayview Manor)

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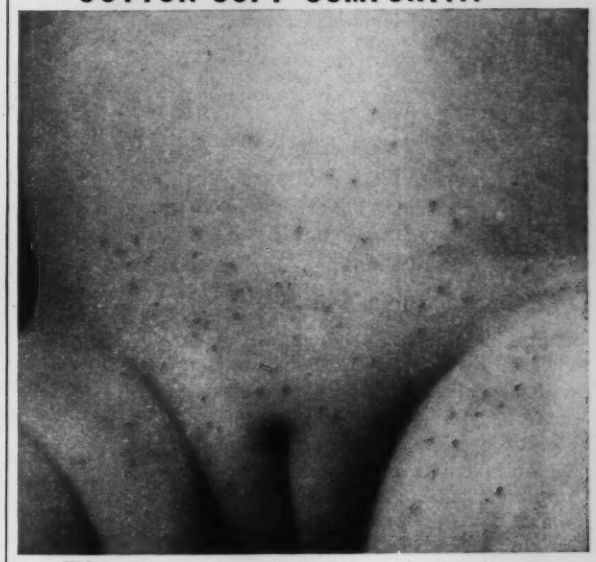

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HOSPITAL_____ FLOOR____

ADDRESS_____

CITY_____ ZONE____ STATE____

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12-14 *Joint Council to Improve the Health Care of the Aged,* Washington, D. C. (Sheraton Park Hotel)
15-19 **Hospital Pharmacy.** Salt Lake City (University of Utah, Union Building)
18-19 New Hampshire Hospital Association, Whitefield (Mountain View House)
21-23 Michigan Hospital Association, Detroit (Sheraton-Cadillac Hotel)

JULY

13-17 **Hospital Purchasing.** East Lansing, Mich. (Kellogg Center, Michigan State University)

Formulary system topic of two talks

(Continued from page 50)

of purchasing drug products at the lowest possible price consistent with acceptable quality.

Mr. Carlin illustrated the complexity of this problem by using ascorbic acid injections as an example: it was found that 38 suppliers list this product at prices ranging from $6.67 to $20.44 per hundred 100 mg. ampuls.

Drug purchasing specification policies used by a government hospital were cited by Mr. Carlin as setting a standard desirable for all hospitals. He said the hospital requires each supplier to certify under oath the following:

1. The company maintains a quality control program equal to or exceeding a standard published by the hospital.

2. The ingredients must meet official, national and state standards.

3. The finished product is manufactured, packaged, and handled according to official, national and state standards and that all finished products, official and non-official, conform to official tests where applicable.

4. The company in the past two years has (or has not) produced a new product and holds thereon an effective new drug application under provisions of the federal food and drug act.

5. The company grants permission for a hospital representative to visit its premises during regular business hours to determine compliance with provisions 1 and 2 above.

6. The hospital requires that, on demand, assay data will be produced by the suppliers.

7. The hospital further requires that successful bidders must post a bond to allow the hospital to assay samples of products of questionable potency or composition at company expense.

ASHP FORMULARY SERVICE

Don E. Francke, D.Sc., chief pharmacist at University Hospital, Ann Arbor, Mich., in his report on the newly launched formulary service of the American Society of Hospital Pharmacists, said between three and four thousand copies of the society's drug monograph collection were to be distributed in January. (Hospitals, through their pharmacy and therapeutics committees, will compile their formularies from this master list.)

The set, which contains 1500 pages, consists of 605 drug monographs listing more than 1600 preparations. The volume is cross-indexed, Mr. Francke said, so that drugs can be found under both proprietary and generic names. He said all ethical products made will eventually be included in the formulary service. ■

Who really uses the nurse-patient communication system

(Continued from page 41)

ward clerk would know exactly where to reach the nursing staff. It is also feasible that several floor systems could be combined into a central station for those hours when the ward clerk is not on duty. One operator could then answer patient calls and transfer these calls to floor staff whose location would be known to her even if the central station was far removed from the floor. Such a recommendation is a logical extension of the voice intercommunication system once the idea is accepted that it functions, not primarily as a nurses' call system, but as an inpatient unit intercommunication system used by staff primarily and by patients secondarily.

The question always arises when a recommendation such as the "personnel locator" is made as to whether staff would use the feature. Will they flick the switch every time they go into a patient's room? If it is convenient and saves time and effort—and these advantages have been demonstrated to them—the chances of their doing so increases. In the case of the locator, an additional factor will be present. The ward clerk and the head nurse will certainly welcome this innovation because they will have the convenience of knowing staff location without effort on their part. The presence or absence of the location light is an automatic signal to them of the degree of staff compliance. The organization of the day inpatient unit staff is such that these two individuals control staff work patterns and can therefore influence their fellow workers to utilize the new feature. The staff on the unit is usually a rather closely knit organization and the span of supervision small, all of which would militate towards the use of a locator valuable to two key members of the group.

The acceptance of the locator device when two or three units are combined for evenings and nights would be an entirely different matter. Here the span of supervision is large and the working relationships between the "operator" and the unit staff rather tenuous. The locator would guarantee the night and evening nurse that all patient requests would be relayed to her, but this alone might not be sufficiently valuable to enforce usage. More education and tighter supervision by the evening and night supervisors might result in a successful utilization of such an installation.

Since one basic tenet of the research approach is the necessity of studying how an area actually functions, rather than how it should function, these projected changes cannot be recommended until evaluated in actual situations. It would be interesting to determine the effect of the recommended changes on the necessity for full view nurses' stations and "gun shot" corridors. ■

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JOHN H. HAYES

There's no fun in being a hypochondriac if you have nobody to whom to tell how sick you are.

★ ★ ★

At about this time the hospital cynic might say, "All these sick people, not so long ago, were sent cards wishing them a happy, healthful new year."

★ ★ ★

With the exception of the recruitment results in the wartime Cadet Nurse Corps years, 1958 saw a new record in student nurse admissions to schools. That's good news, but we want 1959 to be even better; and we should all try to make that possible.

A foreigner, listening for the first time to American daytime television, would get the idea that our wives spend all their time washing clothes.

★ ★ ★

It's sad, but it also is true,
If you're sick in a room built
for two,
Your hopes are much brighter,
And your heart is much lighter
If the other guy's sicker
than you.

★ ★ ★

Why Johnnie has trouble in reading: (and spelling):

"Instead of being rested, the workers returned from their weekend weakened."

"The man re-tired his motorcycle so that he could operate it faster."

"It was his *fate* to be *feted* at *eight*, after which he could not *wait* to go *straight* to bed."

★ ★ ★

When the new AHA building was dedicated a short time ago it occurred to me—and, no doubt, to many others—that we have always had dedicated workers in our old building, as we now have in the new. All of us are happy in knowing that these people now have modern quarters in which to work for us.

★ ★ ★

More "get well" (?) cards to send to people you don't like:

They took out your
gall bladder,
And now you're feeling great.
I'm sure you still have
lots of gall—
They got to you too late.

I'm sorry to learn you have
broken a leg
And your car is an
awful wreck.
The reason I'm sorry is because
—I was told
That you really had broken
your neck.

The hospital says your
condition is good;
And I'm really right glad that
they said it;
But I'm also quite sure that no
hospital would
Ever say that of your credit.

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FOR SALE

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5 GORDON ARMSTRONG MODEL X-P, EXPLOSION PROOF INCUBATORS: equipped with oxygen limiting devices. 2 unused—3 used approximately 2 months. Available at 10% off list price F.O.B. Beth Israel Hospital, Boston, Massachusetts. Please contact: Mr. S. Racoff, Purchasing Department, Beth Israel Hospital, 330 Brookline Avenue, Boston 15, Massachusetts, BEacon 2-4400, Ext. 232.

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FACULTY POSTS: (a) Head new nurs educ div of So. Calif coll; $6-$10,000. (b) Foreign, Turkey; teach nursing principles to English speaking students; good sal, liv. conditions. H2-6

RECORD LIBRARIANS: (a) Chief & dir of schl, med record lib; renowned med ctr; ideal loc; to $7500. (b) 200-bed hosp near Sun Valley; sal commensurate abil. H2-7

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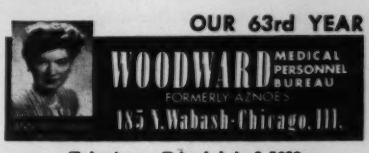

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